The Implementation of Quality Management and the Role of Leadership in Iranian Hospitals

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Abstract

The purpose of this research study is to examine the Implementation of quality management systems in Iranian hospitals with particular emphasis on the role of top management commitment and leadership on quality management (QM) in service organizations. Taking both private and public Iranian hospitals as cases, a conceptual framework based on the theoretical dimensions and the findings is proposed. This study explores how contextual factors influence the implementation of Quality Management (QM) practices. It contributes to the contingency theory of quality management effectiveness. The analysis empirically examines the internal fit between QM and organizational structure, organizational culture and top management commitment as well as its external fit with environmental uncertainty. How these factors affect the implementation of quality management is also considered.

Data were gathered from four hospitals from semi-structured interviews with hospital leaders, hospital managers and other staff who dealt with the implementation of quality management, fundamentally through semi-structured interviews. This was supplemented by document analysis. This research study demonstrates both internal fit and external fit affect implementation of quality management; however, top management commitment has a significant role in quality management implementation. Additionally, the findings offer insights for managers to customize quality management programs to achieve optimal performance benefits. This thesis makes an original contribution to the literature

in integrating a contingency approach to quality management with an emphasis on distributed leadership as an approach to facilitating effective quality management in a hospital context.

Keywords: Quality Management, Leadership, Contingency Theory and Healthcare

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Abbreviations

KCPUB	**Public Hospital in Kermanshah**
TCPRV	**Private Hospital in Tehran**
TCPRV	**Private Hospital in Tehran**
KCPRIV	**Private Hospital in Kermanshah**
QM	**Quality Management**
MBNQA	**Malcolm Baldrige National Quality Award**
EFQM	**European Foundation for Quality Management**
TM	**Top Management**
MM	**Middle Management**
TQM	**Total Quality Management**
MHME	**Ministry of Health and Medical Education**
MSRT	**Ministry of Science, Research and Technology**
MSUs	**Medical Sciences Universities**
MoH	**Ministry of Health**
HCOs	**Healthcare Organizations**
MSU	**Medical Sciences University**
JCI	**Joint Commission International**
UK	**United Kingdom**

USA	**United States of America**
IOM	**Institute of Medicine**
EMRO	**Eastern Mediterranean Regional Office**
WHO	**World Health Organization**
PHC	**Primary Health Care**
DHN	**District Healthcare Network**
ISO	**International Organisation for Standardisation**

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Chapter 1: Introduction

1.0. Introduction

In defining quality Cusins (1994) states, *"I don't know how to define quality, but I know when it's not there"* (p. 26).

There are numerous definitions of quality, for example, *"right first time"*, *"fit for reason"*, *"what the client needs"*, *"conformance to necessities"* and *"value for money"* Crosby (1979) Juran, (1995), Deming (1986, 1939).

There are numerous definitions of quality, for example, *"right first time"*, *"fit for reason"*, *"what the client needs"*, *"conformance to necessities"* and *"value for money"* Crosby (1979) Juran, (1995), Deming (1986, 1939).

In a tremendously competitive market, undergoing dramatic changes in customers' anticipations of value and being impacted by the dramatic revolution in information technology, excellence in quality is becoming an essential requirement for organizations in order to succeed and survive (Jagadeesh, 1999). According to Sayed (2000) Quality Management is considered an essential way to attain the needed excellence in business practice because it offers customer satisfaction through continuous improvement. Quality

is the emphasis of most organizations as it is considered a key business practice and source of competitive advantage (Khan, 2011). Based on Cantrell, Laohavichien, and Fredendall's idea, (2009) top management's commitment and involvement are fundamental to bringing about successful implementation of quality management. To obtain optimal results, similar strategies need long-term involvement. According to Khan (2011) in hospitals quality management is a promising management approach concentrating on the client, the advancement of structures, procedures, and the results of health services.

Hospitals run quality management and development programs for several purposes. Successful outcomes offer considerable advantages through accomplishing customer satisfaction, enhancing employee quality awareness and cognizance, enhancing organizational performance, and supporting organization in value chains (Brown, 2007). These advantages are critical for whole hospital organization, particularly in developing counties, such as Iran, where the quality level is generally low and should be expanded in the pursuit of efficient inter-organizational cooperation (Brown, 2007). Besides, during the process of quality management implementation, hospitals confront a range of difficulties and frequently fail to experience the expected advantages from the implementation of quality management. Related to this issue are research studies done for example by Ruel 2001, and van Harten et al. 2002 who perceived that the procedure of implementation is one of the influential factors of success in introducing approaches in an institute.

This research study can offer valuable results to both hospital leadership and quality management in health care and identify differences and similarities between private and public hospitals. According to Laohavichien et al. (2009), there is lack of research in the role of leadership in implementation of quality management. Consequently, this research study concentrates on the role of leadership in implementation of quality management, and aims at exploring how this is related to the context. As research in quality management matures, researchers require moving beyond simply justifying practices; they now require comprehending the impact of context on quality management practices. A few researchers have begun to develop a refined comprehension of quality management by drawing on contingency theory. This research study explores factors affecting the implementation of quality management from the perspective of hospitals leaders. Furthermore, it identifies the role of hospital leadership in context of implementation of quality management from the perspective of hospitals leaders. The techniques and principles of quality management have only recently been implemented to Iranian hospitals. No reference was found in the literature reviewed for the present study; especially none has investigated the factors associated with the procedure of implementing quality management in Iranian hospitals.

Background of Quality Management in Hospital Environment

From the evidence, in developing countries hospitals spend the greatest share of public health assets (Sayed, 1998). Because of the nature of healthcare activities and consumers, decreasing mistakes and developing effectiveness in hospitals will save not only capital but also lives, as the consumers of hospitals are human lives. According to Brown (2007),

to develop the result of healthcare services, the hospitals need to be constantly and effectively provided with patients. To Wagner et al. health care pioneers have adopted the idea of Quality Management, as bolstered by management academics and industrial designers (2003). The main bulk of management philosophy is upholding quality and leadership responsibility that offers the basis for continuous quality improvement (Brown, 2007). Brown (2007) and Donabedian's (1988) connect the definition of quality health care services to agreeability with preset principles: standards are advanced when specialists have the capacity to comprehend what the right things are and how the right things are best accomplished. In this way, quality can be said is complying with the standards.

According to Brown (2007) executing quality management in health care associations can enhance patient safety, improve financial effectiveness through greatly enhanced expense management practices, and move the health care service from its present low execution level to new principle of superiority. In additional, the Institute of Medicine (2001) provides the outcomes of two substantial investigations of adverse occasions taking place in the mid 1990s and shows that 44,000 to 98,000 Americans die every year because of medicinal errors.

Moreover, implementing quality management in health care, which is a patient-centered procedure, contributes to making health services safe, enhances health results, promotes effective patient care, and promotes patients' satisfaction, if the procedures are designed, implemented, actualized and reliably executed (Schyve, 2000). The quality

management methodology has the potential to bring about significant change in both quality and cost in healthcare organizations; however, it is still hard to be implemented (Trisolini, 2002). Healthcare management must pick up experience and training with a wide arrangement of business management models (Trisolini, 2002).

Tamimi and Sebastianelli (1998) identify numerous issues that organizations might experience while implementing quality management. Significant issues cited by organizations include the inability to connect management remuneration to the accomplishment of quality objectives, insufficient worker training and lack of resources for utilizing quality management, though the most essential issues are an absence of top management commitment and an inability to concentrate on strategic planning. Subsequently, this research will investigate the implementation of quality management in Iranian hospitals with particular emphasis on the role of hospital leadership in implementation of quality management and identifies the factors affecting implementation of quality management.

1.1. Research Problem

A review of the literature demonstrates that it is extremely significant for organizations included in quality management activities to comprehend and manage the factors effective in the implementation procedure. According to Hill and Wilkinson, (1995) some scholars recognized that British organizations are having issues with the implementation of quality management. The detailed review of literature on implementing quality management in hospitals indicates that there is a gap in tackling the

factors associated with their successful implementation hospitals. The standards and procedures of quality management have just been applied to Iranian clinics. No reference investigating the factors, especially those associated with the procedure of quality management in Iranian hospitals found in the literature reviewed. Therefore, based in the gaps recognized, the present research study is interested in investigating the effecting factor in implementation of quality management systems. This research is a contribution to bridging this gap, so helping health professionals and managers to implement the quality management systems in successfully Iranian hospitals. This current research study discusses these factors with a focus on public and private Iranian hospitals.

Researchers also have concentrated on factors influencing quality management such as the role of organizational culture, organizational structure and environmental factors, which affect the implementation of quality management. However, the variables influencing quality management implementation and the role of leadership in quality management have been largely ignored. Therefore, based on the gaps recognized, this research study is keen to explore the role of leadership in quality management practices and investigate internal and external factors in implementation of quality management.

Theoretically, there has been no satisfactory examination of quality management practices in hospital environment. Laohavichien et al. (2009) assert that existing leadership approach has not been used in the area of quality management. They express that, “a significant part of the existing quality management research has not utilized any concepts from leadership approach to assess the prominence of leadership in quality management”. Laksham (2006) states that, “the role of leadership in managing as an

authentic role of the leaders has not got much consideration". A comparative suggestion is offered by Berson and Linton (2005), who emphasize the requirement for future research in analyzing the relationship between leadership styles and quality management practices. Ovretveit (2005) claims that a percentage of the existing research has brought up questions about the extent of impact, top management has over quality improvement, and there is no strong proof demonstrating which management activities are effective to improve quality. Sousa and Voss (2002) additionally propose that to analyze the role of leadership on quality management further research ought to be directed.

Moreover, according to Othman and Owen (2002) the conflict between doctors and hospital leaders needs to be investigated as this undermines implementation of quality management. Othman and Owen (2002) assert this theme should be dealt with more comprehensively as it increases the role of leader in quality management from a practical viewpoint.

It is very important for healthcare organizations embarking on a total quality management journey to understand how to implement quality management systems. Hospitals need to understand how to implement QM to achieve the maximum benefit. Different hospitals private and public may need different approaches to QM. Westphal et al. (1997) studied QM implementation in hospitals, and found that hospitals that customized the QM practices had higher performance than hospitals that adopted standardized approaches to QM. However, their study did not provide an explanation about how organizations can customize QM practices. This current research study draws

on contingency theory and express that the contribution of different QMSs practices to performance depends on contextual factors.

This research study will provide broad review on the components of quality management framework in particular and hospital leadership in general. The research would be profitable regarding the implementation of quality management and also the role of leadership in quality management in Iran, which can be generalized to Middle East. Such knowledge would be profitable as the greater parts of research being done are related to Western nations. It is expected that this research reveal new insight into the implementation of quality management and the role of leaders in adopting change in Iranian hospitals.

In order to comprehend any research, it is necessary to define an appropriate methodology as indicated by its objectives, so the researcher follows the research procedures towards fulfilling the objectives. The detail of the undertaken methodology is given in section 5 (methodology) and just a summary is clarified here.

1.2. Theoretical Framework

There are various contending complementary theories that can be expanded after developing quality management framework strategies and leadership, which will be discussed more completely in Chapters 2 and 3. Among the theories related to leadership and quality management, ‘contingency theory’ was found to be the most relevant to the concept of this thesis.

The theory and this thesis both reject the notion that there is one appropriate approach to management because circumstances often differ. While managing quality, it ought to be emphasized that every hospital has its own particular conditions, which along with these lines, needs suitable management practices and specifications. Some writers have realized the significance of contingency theory in Operations Management (Lawrence and Lorsch, 1967; Thompson, 1967; Sousa and Voss, 2001, 2008). Researchers require moving beyond solely justifying practices. They have to improve the influence of context on implementation of quality management process (Sousa and Voss, 2001, 2008). Many researchers have begun to improve a refined comprehension of quality management by drawing on contingency theory. Some scholars raise doubt about *"universal validity"* of QM practices (Foster 2006, Sousa and Voss, 2008). According to Foster (2006), it is necessary to take contingency theory into account while implementing quality management. It is believed that the changeable performance in implementation of quality management might be due to contextual factors (Foster 2006; Nair 2006; Sousa and Voss, 2008). Future research in quality management should study contingency theory (Nair 2006).

Contingency theory focuses on the relationship between the organization and contextual variables, expressing that these variables influence the organization and consequently the quality management they are implementing. Accordingly, to implement any quality management, the particular variables connected with it ought to be considered and assessed (Gong and Tse, 2009). The literature has emphasized the significant effects

of internal and external environmental variables. Some researchers (Burton et al., 2002; Burton and Obel, 2004) have a multi-contingency framework to comprehend how diverse elements influence performance. Siggelkow (2001) constructs a difference between external and internal fit. External fit looks at interactions with the external environment, while internal fit looks at interactions with the internal structure of the organization. Burton et al., (2002) assert the structure of an institute is not independent from the environment that an institute is fronting.

As the external and internal factors influence how any quality management is implemented (Zhang, Linderman and Schroeder, 2012), this research study is situated geographically and transiently inside a particular environment. Considering the unstable economic, political and social conditions in Iran, Iran would be a suitable case to be assessed here for an in-depth analysis of the impacts of internal and external factors on implementation of quality management. Furthermore, Iran is a suitable case to assess the implementation of quality management in Iranian hospitals with particular emphasis on the role of hospital leadership. An extensive discussion (economic, social, and political features) is presented in Chapter 5 (Methodology); furthermore, the rationale to select Iran and reasons why it is selected as the case study of thesis are given in chapter 5. In this chapter, just a brief introduction about Iran, a brief history of healthcare services, and assessment of hospitals in Iran are clarified.

1.2.1. Research Approach

The research was conducted using *case study* methods. Contextual data and secondary data are utilized for the thesis and are examined thoroughly in chapters two, three, four (Literature review) and 5 (Methodology). The research strategy is qualitative; and for gathering data, interviews were used; and the participants were three categories of performers in each hospital: the leader of the hospital, the quality improvement managers and doctors who have quality management responsibility.

1.3. The Need for the Study

The significance of quality in the Iranian service industries has developed lately. Decision makers in the nation have begun to accept that implementing quality system is a crucial source of competitive advantage for all organizations including health care suppliers (Hamidi, 2008).

Numerous governmental awards have been founded to perceive organizations that have accomplished excellent quality levels in different industries, counting health service industries. Some healthcare organizations have begun to include quality strategies in their administrative frameworks and operations. This quality development going for changing the business environment and practices help associations to recognize and manage the factors affecting the implementation of quality management (QM). Healthcare organizations include a critical business range, which includes adopting such frameworks to enhance quality and patient security.

A detailed review of literature on implementing quality management in hospitals demonstrates that there is a gap in handling the factors connected with their effective implementation in hospitals. This research study contributes to spanning this gap, thus assists health service decision makers and top management to effectively implement quality management framework in Iranian hospitals. Besides discussing these factors, this research deals with the role of hospital leadership as internal factor with an emphasis on the public and private hospitals.

1.4. The Healthcare System in Iran

Iran is a governing member of the Eastern Mediterranean Regional Office (EMRO) of the World Health Organization (WHO). EMRO incorporates nations from the Middle East (Mohit, 2000).

The statute of I.R.I. guarantees all residents a privilege of access to health care services (I.R.I., 1979b, 2004). To do so, the MoH, as a definitive authority of the country's health care, is in charge of leading, planning, supervising, funding, policy-making, and assessing the health services and medical education in the nation (Mohit, 2000).

However, the executive responsibility has been put on the shoulders of the Medical Science Universities and Health Services at provincial level. These duties include the tasks of providing healthcare services and training the required human resources at all levels of education (Majlis, 1985; 1987; 1988a). While the MoH is essentially concerned

with questions of policy-making and financing, the UMSs are responsible for managing, organizing and delivering health services at provincial levels. The UMSs, at least one in each province, play an important role both in medical education and provision of health services. The chancellors of the universities, who are also apparently the deputies of the health minister in their respective province, are the executive directors of the provincial health services and in charge of all hospitals and health centres.

Providing healthcare services in the country at provincial level is undertaken at three levels: primary, secondary and tertiary (Anonymous, 2008). Primary health care, the most accessible services geographically, are provided in rural areas by some basic health centres called Health Houses (HHs) as well as on a limited scale in urban areas, especially in small cities, by Health Bases (HBs), the equivalent of Health Houses in urban areas. These are under the supervision of Rural and Urban Healthcare centres respectively. The secondary level includes the more advanced services; initial access to district hospitals is made possible at this level (Shadpour, 2000). The first and second levels are included in a District Healthcare Network (DHN) and the hospital at this level is the first point of referral from the lower level. The district, in Iran's healthcare system, is the smallest autonomous region and the most natural administrative level promoted by the WHO for healthcare delivery (Mohit, 2000). The DHN provides support and supervision for the centres at primary and secondary levels. The services delivered in all the DHNs are called 'primary health care (PHC)', which was accepted by the member states of the WHO as the key to achieving the goal of health for all (WHO, 1978). A primary healthcare centre is the basic structural and functional unit of the public health

services in developing countries and was established to provide accessible, affordable and available primary health care to people, in accordance with the Alma-Ata Declaration (Tarimo, 1991). As for the importance of district level health care, Tarimo (1991) has indicated that each district covers not only a small enough area that staff are able to understand the major problems and constraints of its socio-economic and health development, but also large enough to develop the technical and managerial skills central to its planning and management. The organisational layout of all health centres at district level is displayed (figure 1.1). Tertiary level includes the UMSs and hospitals that provide the most advanced healthcare services in the country. This level is the final referral point of service for lower levels of health service delivery process.

Nonetheless, the official commitment has been put on the shoulders of the Health Services (UMSHSs) and of Medical Science Universities at provincial stage. These responsibilities incorporate the assignments of giving healthcare services and training HR (human resource) at all levels of training (Majlis, 1985; 1987; 1988a). While the MoH is basically concerned with inquiries of financing and policy-making, the UMSs is in charge of delivery of health services and management at provincial levels. There is at least one UMS in each province, which plays a vital role both in provision of health services and medical education. The leaders of the universities, who are likewise the deputies of the health minister in their respective province, are the executives leaders of the provincial health services and responsible for all health centers and hospitals.

The focus of healthcare services is the fundamental structural unit of the public health services in developing nations and was set up to offer affordable and accessible primary health care to individuals, based on the Alma-Ata Declaration (Tarimo, 1991). About the significance of area level health care, Tarimo (1991) has demonstrated that each area covers not just a sufficiently small region whose staffs have the capacity to comprehend the major difficulties of its financial and health advancement, but sufficiently extensive units to advance the managerial and technical skills integral to its management and planning. The hierarchical design of all health focuses at area level is indicated in figure 1.1.

Tertiary level incorporates hospitals and the UMSs that offer the most progressive healthcare services in Iran. This level is the last referral purpose of health service for lower levels of health service system delivery procedure.

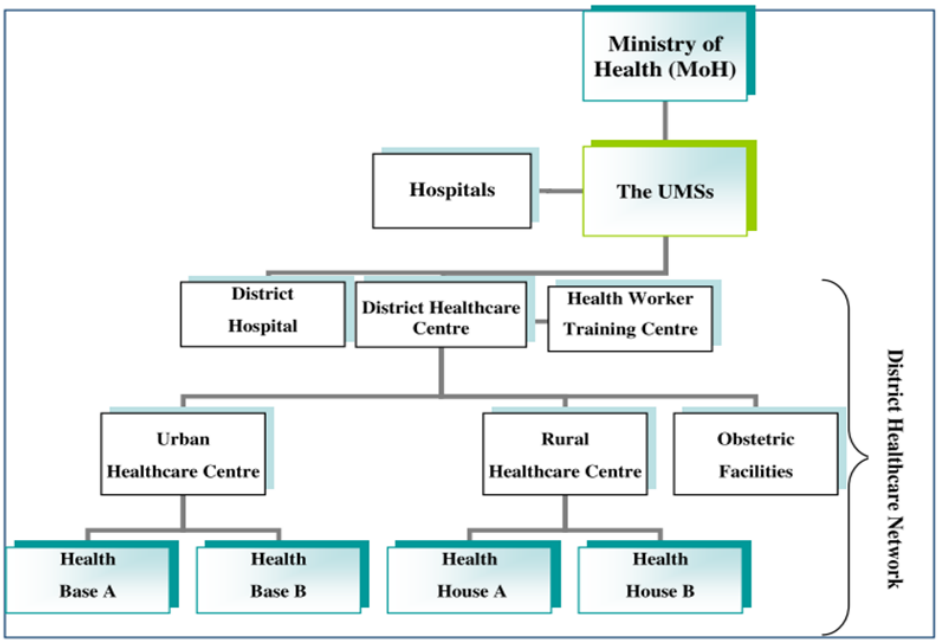


Figure: 1.1. Structural Chart of Iran's Healthcare System Organisation (Source: Sadaghiani and Zare 2005).

1.4.1. Tertiary level of Healthcare Delivery-Hospitals

Both general and specialized hospitals are situated at this level of the healthcare services framework. These Healthcare organizations (HCOs) are the fundamental bodies offering and conveying progressive clinical and medical services in Iran, predominantly in the cities (Mohit, 2000). There are two principle classes of hospitals in the Iranian healthcare system, to be specific public and private, or governmental and non-governmental (Figure 1.2). The government possesses state hospitals while non-governmental associations; individuals or bodies possess private ones. These two classes can be further subdivided into more classes (Mohit, 2000). The case in point, private hospitals are put into for-profit and not-profit (charity) and the public hospitals are divided into institutional and university hospitals. The university hospitals are those that are operated and governed under direct control and supervision of the UMSs. These are additionally divided into two groups: the clinical hospitals that are accountable for delivering clinical services and teaching hospitals which provide clinical services and undertake medical training, education and research.

The fundamental financial resource of all the hospitals is provided through their income from the services they deliver. The public hospitals are incompletely funded by the state through a focal budget scheme. The services of the hospitals are valued according to the accreditation grade (explained below) of the hospitals. That is, the hospitals must satisfy various regulatory necessities, set by the MoH and checked through the UMSs, to be permitted to charge the highest rate for their services.

The accreditation and assessment of healthcare organizations (HCOs) in Iran at present just include the hospitals, but not other healthcare centres (Sadaghiani and Zare, 2005), this research study will concern itself just with the hospitals to keep up its relevancy to the principle objectives of this research, which is analyzing the role of hospital leadership in quality management in Iranian hospitals. In this research, the hospital referred to as private and public.

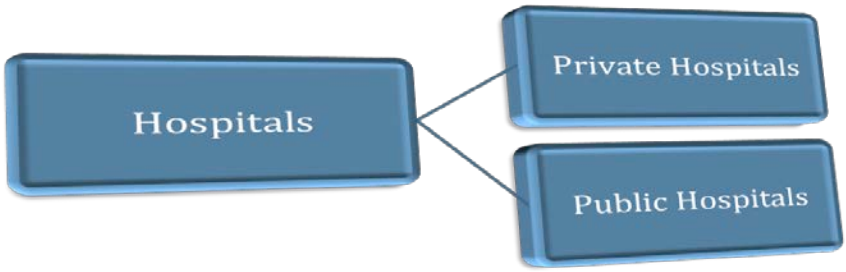


Figure: (1.2.) Categorization of Hospitals in Iran's Health System (Source: Researcher)

Iranian political leaders make promises of advancing healthcare services by strictly implementing international quality standards. Accordingly, to meet the requirements of the Iranian Government (the Universities of Medical Sciences and Health Services) in 2009 decided to adopt quality management standards in all private and public hospitals.

With growing competition, rising patient expectations, and advances in medical sciences, the health care frameworks has got to be complex organizations. Iranian health care requires achieving an optimal balance between the assets and patient satisfaction.

Quality management (QM) has a notable potential to address quality issues in an extensive variety of industries and enhance the Iranian organizational execution.

Thus, Iran has been picked as the case study of this thesis as it can provide 'analytical' generalization beyond Iran to discover the sort of quality management, how it is implemented, and investigates the role of hospital leadership in quality management and also how quality can be managed depending on the situation.

1.5. Aim, Objectives and Research Questions

The aim of this thesis is to examine the Implementation of quality management systems in Iranian hospitals with particular emphasis on the role of Leadership.
The following questions will be investigated by this research study:

1. What kind of quality management systems do Iranian hospitals use?
    - To investigate the types of quality system and to evaluate their performance in those hospitals.
    - To investigate how quality management system implement in those hospitals.
    - To investigate internal and external factors affecting the implementation of quality management.
    - To investigate the barriers to quality management system implementation.
    - To investigate public and private barriers in quality management system.

2. What is the role of leadership in quality management systems in Iranian hospitals?
    - To determine pattern of leadership in leading quality management in the context of hospital.
    - To identify, explore and examine the relationship between leaders, doctors (professional) and government.
    - To find public and private hospitals differences.

3. What are the similarities and differences between quality management in Iranian hospitals?
    - To find the similarities and differences between private and public Iranian hospitals in terms of their quality management systems and compare different developed and less developed cities (Tehran and Kermanshah).
    - To find the similarities and differences between private and public Iranian hospitals in terms of influential factors in implementing quality management

1.6. The Rationale for the Research

This research study will likewise provide some profitable findings to implement in quality management in Iranian healthcare services framework. Whilst there has been a significant amount of research on quality management implementation in Western and developed countries, the same cannot be said in regards to this strategy's presence in the Middle East. Besides, it is the first time that research emphasizes on the role of leadership on implementation of quality management system in both public and private hospitals in

order to investigate which quality management systems are used and what are the differences and similarities of private and public hospital leadership, and quality management system in two different cities, one in capital city as a developed city (Tehran) and another in less developing city (Kermanshah) and thus compare Iranian hospitals.

The role of managing quality is fundamental in today's surroundings, as shown by the prominence of the Quality Management (QM) development and the success it has conveyed to various organizations (Easton & Jarrell, 1998; Douglas & Judge, 2001; and Hendricks & Singhal, 1997). However, the role of hospital leadership in managing quality is moderately unaddressed in the quality management literature. Furthermore, research in quality management as a legitimate role of leaders has not got much consideration (Waldman, 1993) in leadership literature. Accordingly, the potential for coordinating the leadership literature with the quality management literature is great and is liable to be helpful for both practices in hospitals and in theory. This research study is an attempt at such integration of the leadership and quality management literatures.

This study will reveal insight into the role of hospital leadership in quality management system that focuses on private and public sectors in Iran. As Iranian policy and law is profoundly imbedded in religious qualities, it makes an interesting case. It would also be helpful to explore how Iranian hospitals function in Islamic environment and contrast with developed nations, for example, England, Canada and America in terms of organizational structure, organizational and managerial structure and the factors affecting

quality management. The importance of conducting this research study lays in its contribution to promote the knowledge of leadership in quality management system implementation in healthcare. Lastly, it contributes to the improvement of the body of theoretical knowledge in the area of healthcare services, and offers some tools of analysis that may be of value to hospital administrative service managers.

This current research study is taking a gander at factors influencing quality management in Iranian hospitals, and how the impacts of environment and interactivities of factors on every hospital. Furthermore, contingency theory will be utilizing for implementation of quality management.

Because of the unique nature of this research study, the investigation will document strategies of an expanding and innovative health care industry, operating inside a country that lacks research. Consequently, this research will likewise contribute to the extension of knowledge in the Middle East. Various benefits will occur from this research, for example, examining the Implementation of quality management systems in Iranian hospitals with particular emphasis on the role of Leadership the role of leadership in implementing quality management system in private and public hospitals.

1.7. The Overall Research Structure

Chapters Two, Three, and Four: Literature Review: The literature review was split into three chapters. The first part of literature reviews the quality and quality management, explains the concept of quality management (the focus of this thesis) in general and in the

context of hospital, characterizes the implementation of quality management process and refers to its sub-procedures, reviews related research studies and papers embraced by other investigators, and examines their findings. The second part of literature review explores leadership theories and the role of leadership in implementation of quality management. The third part of literature highlights the factors influencing the quality management implementation. Furthermore, it assesses various management theories and quality management and discusses the justification of choosing contingency theory as the theoretical framework of this research, analyzes the contingency theory in context of quality management in hospital, and finally displays the research questions which are replied through comprehension this thesis. The literature review permitted the researcher to comprehend the ideas of quality management implementation in hospitals and to produce the interview questions.

Chapter Five: Methodology discusses the favored research methodology attempted for answering the questions of the research study; defines the adopted research methodology; examines the rational for the decision of research designs followed by a critical assessment of the case study strategy; and discusses the reasons behind selecting Iran as the case study strategy; recognizes the research methodology and reviews previous studies, their methods and data collection techniques to justify the selected data gathering strategies for this research study; clarifies the sample size for the interviews; distinguishes the data analysis approaches utilized; and finally discusses facts and ethical consideration of the thesis.

Chapter Six: Interview Analysis: as the second piece of data analysis deals with qualitative information gathered through conducting interviews; examinations the content of questions one by one; demonstrating the coding scheme for every question; and presenting question; and presenting quotations while discussing their responses.

Chapter Seven: Discussion: reviews and argues the data gathered and analyses information in connection to the findings of other authors argued in Literature Review chapters and contextual information about Iran argued in methodology chapter; responses the research questions; and lastly discusses the results in relation to the contingency theory.

Chapter Eight: Conclusion and Recommendation: In the last chapter of this research study, a general conclusion is displayed in connection to objectives and the research aim. It summarizes the findings of the research study; discusses the contributions to knowledge; clarifies the restrictions of this research study and offers recommendations to further research in this area.

1.8. Chapter Summary

This chapter has provided an insight into the research study, presenting a brief outline of quality management and its contextual. It has considered particularly the case of the Iranian healthcare, justifying the requirement for the study, and has distinguished the research goal and objectives to be accomplished. In additional, the possible contributions to knowledge have been recognized. A layout of the research procedure has additionally

been given. The following chapter will address the current literature in the quality management and quality management implementation.

Outline

The previous chapter reviewed the relevant literature on quality management theory with an emphasis on health care, more specifically on hospital research. The literature review is split up into three chapters, which are the Concepts of Quality Management, the Leadership Theories and Leadership in Context and also Factors Effecting Implementation of Quality Management. The quality management literature emphasized the significant of leadership in implementation of quality management process, as the aim of this research study is to examine the Implementation of quality management systems in Iranian hospitals with particular emphasis on the role of Leadership as a result this chapter reviews leadership theories.

The leadership theory chapter seeks to provide an extensive overview on leadership. First, it sets out to review and present some common ideas and models regarding leadership. The study of leadership has established a large pool of theoretical materials related to leadership theories since 1900s. An extensive review of studies on leadership notions is fundamental; it would help the researchers to comprehend the leadership idea historically. It is clear that comprehending leadership concept provides a clear path to the study. This chapter is split up into eight main segments discussing leadership theories. All seven segments are significant in assisting the researcher to improve her knowledge to accomplish this research study.

Finally the chapter of Factors Effecting Implementation of Quality Management examines effective factors in implementing quality management. This chapter also develops a conceptual framework.

Literature Review

The aim of a literature review is to locate and evaluate current knowledge in the area of research topic, which in this case is the Quality Management within the context of healthcare and hospitals (with particular emphasize on Iranian hospitals private and public). The aim of these chapters is to help the reader understand how the researcher generated and refined the research ideas and how these ideas were informed via a critical review of existing theories and studies (Sharp and Howard, 1996). The literature review serves to identify the gap in the previous research and literature to facilitate development of the relevant research question for this study, which was outlined in the previous chapter.

These chapters review the relevant literature on quality management with an emphasis on the role of leadership in implementing quality management. The concept of quality management in general and in the context of hospitals is clarified and its management process and sub-processes are discussed. Then the review underlines the factors influencing the quality management process. Related studies undertaken by other researchers are reviewed and their findings are discussed. Management and quality management theories are then evaluated and the selection of contingency theory as the theoretical framework of this thesis is argued. Finally, contingency theory is examined in the context of quality management, leading to the presentation of research questions to be addressed by this thesis.

The review will cover the following key areas:

- A discussion of the philosophies and principles of quality, quality management, quality gurus and their contributions to quality management system.

- A discussion of the implementation of quality management, principles, underlining similarities and differences with the International Standardization Organisation (ISO) and European Foundation for Quality Management (EFQM) equivalents.

- The elements affecting the quality management system implementation based on the components of quality management in organisations in overall and in hospitals in particular.

- A discussion of quality management in manufacturing and service, and also highlighting the similarities and differences between these area, particularly emphasizing the hospital sector as this was chosen as a case organization for this research study. In addition, quality management in the context of private and public hospitals will be discussed.

- The national culture, a discussion of QM in developed and developing countries in general and in the Iranian environment in particular, as Iranian hospitals were

selected for case study. This contains the definition of culture and the influence of cultural dissimilarity on management systems, and quality trends in Iran.

Research Strategy Utilized in the Literature Review

The following points are considered in the literature review:

- In the discussion of the quality concepts of quality management (QM), the investigator analyses the work of quality gurus like Juran, Crosby, Deming, Ishikawa, and others because of their pioneering contributions to the body of knowledge in the concepts of QM. This research study was noted that some including Deming, did not use the term QM; but the concept of QM was utilized as suitable. The work of several other writers was examined in the field of quality principles, QM implementation in general and health care in particular. In additional, an author, who has been normally utilized and merely utilized for several chapters, is Barrie G. Dale and the co-writers of "*Quality Management*". The choice is based on the fact that Dale has specifically examined quality, quality management systems in the last 20 years. Moreover, many other authors have also cited his books and articles while researching QMSs. Dale has presented theories on the quality management systems implementation and the attempt for total quality management and how organizations can develop their work towards quality. This research study discovered that papers had been published on the quality management implementation and QM of hospitals by numerous scholars, involving Hendrich et al. (2007), Yu and Houston (2007),

Furman and Caplan (2007) Huq and Martin (2000) Yang (2003), Ruiz and Simon (2004) and Pomey et al. (2004). It is necessary to review the leadership theories as this study focuses on the role of leadership in implementation of quality management.

- In conducting the search, the researcher examined merely literature published in English and utilized the search terms *'quality management'*, *'TQM implementation'*, *'quality management in hospitals'*, *'factors affecting QM implementation '*, *'factors affecting the quality management implementation in hospitals'*, *'hospital leadership' and 'role of leadership'*. The EBSCO and Emerald databases were mostly utilized to perform this search since the greatest relevant journals and papers could be discovered there. Several of the papers studied in these databases covered literature specific to hospital leadership and the quality management implementation in hospitals. More than one thousand documents were found under the beyond search terms. The researcher ultimately chose more than three hundred journals to be utilized in this research study or to spread her knowledge of the subject.

- Some additional literature was reviewed and recognized following the empirical step of research and throughout the discussion of the empirical findings of the four case studies. In additional, the justification for this review was to guarantee that the research results could be examined in the context of previous research studies and theoretical clarifications in order to distinguish the similarities and

differences between manufacturing and service identified in the literature review and the consistent findings of the case studies. In addition, it identifies the similarities and differences between private and public. In additional, this will offer opportunities to examine any new matters that appear from the case study results not forecast in the literature.

- To assess the strength of the literature and to distinguish between academic research papers and other points of literature such as magazine articles, the researcher measured the subsequent elements affecting the choice of literature: Is the article peer-reviewed? Is the paper (article) appropriate to the topic under examination? Is it established on empirical research with a suitable approach? These facts directed the researcher in recognizing the role of leadership in implementation of quality management and also the factors that affect the quality management implementation in hospitals. Moreover, in some conditions, the researcher found references to appropriate PhD theses related to the results of articles and case studies in particular frameworks. The researcher has been constant to make sure that when reviewing any part of this research study, the priority be given to peer-reviewed research papers.

Chapter 2: Concepts of Quality Management (I)

2.0. Introduction

The literature review purpose is to understand the present knowledge of the notions in the philosophy of quality management. The main intention is to recognize the notion of quality management and the feature of quality management in general and environment healthcare in the hospital in particular. These notions are significant since they assist to investigate the research question, underline the future accomplishment of the implementation quality management system framework, and recognize the role of leadership in quality management. The outcomes of the literature review will guide the researcher to study the implementation of quality management and also the role of leadership in implementation of quality management. In the framework of the research question, the following concepts areas are investigated: (a) the concepts of quality and expansion of quality management, (b) the main framework and philosophies of quality management, (c) implementing a quality management system, (d) quality management in manufacturing and service sectors, (e) quality management in developed and developing countries, and (f) quality management in private and public sectors.

2.1. Initial Principles of Quality and Development of Quality Management

We need to describe the phrase "*quality*" before reviewing quality management. The Oxford Dictionary (1999) defines quality as concerned with "*the value and degree of excellence*".

Academics have stated that one of the difficulties associated with quality management is the shortage of a comprehensively accepted meaning of quality (Eng & Yusof, 2003). The concept of quality may appear evident; however, it is difficult to describe. There are many definitions of quality some of which are given below.

Juran defined quality based on a multiple meaning, (1) "*Quality contains those product features which meet the needs of customers and thereby provide product satisfaction*", and (2) *quality is apparently associated with customers' requirements, and fitness suggests conformance to measurable product characteristics*" (Juran, 1988, P.22). In addition, Deming's definition is "multidimensional *to produce a product and/or deliver a service that meets the customer's expectations to ensure customer satisfaction*" (Deming 1986, P.54). Crosby defined quality as "*conformance to requirements*" (1979, P.7).

In 1996, Huq stated that several leaders of healthcare institutes have defined quality as constantly developing services to exceed and meet the expectations of their customers.

Cusins (1994) states, *"I don't know how to define quality, but I know when it's not there"* (p. 26). This statement underlines the problem of defining quality precisely. Moreover, the perception and definition of quality varies among individuals, and actually depends on each individual's perspectives and values. However, "[n]ew definitions have not replaced the old ones; rather, all of the quality definitions continue to be used today. No definition of quality best fits every situation" (Reeves and Bednar, 1994). To standardise a descriptive meaning of quality, the International Standard Organization defines quality in the ISO 8402:1994 Quality Vocabulary as *"the totality of features and characteristics of a product or services that bear on its ability to satisfy the stated and implied needs"*. According to Pirsing (1974), the notion of quality is as elusive as it is pervasive. The difficulty of definition consequently makes it difficult to attain worldwide agreement on the notion. Therefore, instead of attempting to impose a worldwide definition on the term, depending on the conditions diverse definitions of quality have been used (Garvin, 1988; Reeves & Bednar, 1994, Stensaker, 2004). Consequently, this research study needs to find out the definition of quality used in the case study organizations.

The recent improvement and history of the quality movement and the improvement of quality management frameworks are presented in this segment of the literature review.

2.2. Quality Management System Principles and Framework

Many tools, methods and models are presented in scientific literature to improve the quality of services and products. Some tools such as philosophy of quality management are very widely employed; others such as statistical evaluation of procedures are particularly dedicated to the specific action of the enterprise. Some quality management methods are comprehensible as the philosophies, principles or requirements; however, they do not reveal the tools and methods that would help to implement those requirements and principles and that in turn negatively influences the useful implementation of the requirements. There is a large volume of published studies (Cao et al., 2000; Nwabueze, 2001; Srdoc et al., 2005; Lagrosen and Lagrosen, 2006; Martin-Castilla et al., 2008; Ehlers, 2009; and Pabedinskaitė et al., 2008, 2010) describing the extra causes that determine the adequate outcomes of implementation of quality management tools such as the shortage of training, motivation and authority commitment, not paying enough attention to human resources as one of the most imperative features of quality management, and not adequate organization in total quality management tool.

Previous research has indicated that quality management tools and their practical application remain significant scientific challenges. Based on extensive review of the conceptual and empirical literature on QM, its decision should be based on quality management specialists, applying and developing those quality management systems, experiences and proposals which would let determine what actions and decisions would allow to develop the efficiency of quality management system.

Research into QM has a long history. The contributions from quality pioneers have had an effect upon future findings regarding total quality management. The studies on TQM have progressively improved, and a large and growing body of literature has identified numerous practices for efficient quality management. Juran & Gryna, (1993) pioneers of quality believe that the method (system) and management are the reasons of poor quality rather than personnel involvement. However, the next section reviews the contribution to quality journey (quality gurus) reinforced by some references, in order to understand the history of quality management in depth.

2.2.1. Quality Gurus

A large and growing body of quality management literature has researched the quality management philosophies and principles of quality leaders such as Deming, Crosby and Juran. According to Sila and Ebrahimpour, (2003) quality gurus have been critical in the development of total quality management contexts with their philosophies.

Deming proposed the Plan-Do-Check-Act (PDCA) Cycle and the fourteen points of management, which today are still utilized. He suggested that attaining high levels of quality is almost entirely dependent on the management responsible for the producing the merchandise (Deming, 1986).

Deming identified a specific field quality improvement, called *"System of Profound Knowledge"*. The phrase 'profound' means the deep perceptiveness that science offers to make transformations effective in developments in a diversity of settings, whereas

'system' means a stress on the collaboration of the factors rather than on the factors themselves. According to Deming, (1993, p50) *"A system is a network of interdependent components that work together trying to fulfill the aim of the system"*.

Ishikawa made many contributions to quality. He offered Total Quality control (TQC) in a Japanese style. Company Wide Quality Control (CWQC) defines that *"Quality control consists of developing, designing, producing, marketing and servicing products and services with optimum cost-effectiveness and usefulness, which customers will purchase with satisfaction. To achieve these aims, all the separate parts of a company must work together"* (1989). Table 2.1 compares the approaches to QM of the most significant leaders.

Juran described TQM as a widespread management method targeting at satisfying the customer, as he is one of the most influential factors affecting the quality. Juran describes three quality management procedures: quality planning, quality control and quality improvement, which are well known as the *"Juran Trilogy"*. According to Brown (2005), these processes offer a rational model for comprehending the entire quality management. Sila and Ebrahimpour (2003) state that Deming and Juran both assert quality management notions are universally applicable. The zero defects notion and *"Quality is free*" notion are offered by Crosby (1989).

Feigenbaum (1991) is famous as the initiator of total quality control. He offered three stages to quality: Organizational commitment, Quality leadership, and Modern quality

technology. He believed that TQM needs a high degree of effective functional incorporation among individuals, information, and machines, emphasizing on methodical approach quality. In addition, he clearly defined total quality system as an influential basis for total quality management. To him, quality is the accountability of everyone in the organization, depending on organizational structure and organizational culture.

Table 2.1: The Approaches to Quality Management of some Quality Gurus

Dimensions	Deming	Juran	Ishikawa	Feigenbaum	Crosby
Top Management Support	No Significant Distinctions	No Significant Distinctions	No Significant Distinctions	No Significant Distinctions	No Significant Distinctions
Supplier Relationship	No Significant Distinctions	He considers that for important purchase it is well to use multiple sources of supply	He considers that the number of suppliers has to be two. Only one supplier can be dangerous.	The significance long-term interactions and decrease in the number of providers are not considered.	No Significant Distinctions
Role of the Quality Department	No Significant Distinctions	No Significant Distinctions	He emphasizes the involvement of all employees studying and promoting quality control. It has not been an exclusive	He emphasizes to the need have a management function whose only area of operation in the quality control jobs. He considers that although quality is	No Significant Distinctions

			dominate specialists. He does not any specific comment about quality departments.	everybody's job, it might become nobody's job if this department does not exist.	
Workforce Management	Except the importance of training, he scarcely considers this factor. From his improvemen t is basically a manager's work	No Significance Distinctions	He stresses the significance of quality circles.	Empowerment and teamwork are scarcely considered.	He does not consider empowermen t.
Employee Attitudes and Behavior	Motivational campaigns are useless	Motivation dose not assure zero defects production.	No important differences	No important differences	No important differences
Product Design Process	Not considered	Not important differences	Not important differences	No important differences	Not considered
Process Flow Management	He focuses on the need to maintain the process under statistical control. He criticizes the zero defects approach and sampling inspection.	No important differences	No important differences	No important differences	He focuses on the need to achieve zero defects through prevention.

Quality Data and Reporting	Not considered	No significant distinctions	No significant distinctions	Not considered	No significant distinctions
Customer Relationship	No significant distinctions	No significant distinctions	No significant distinctions	No significant distinctions	No significant distinctions
Benchmarking	Not considered	Not considered	Not considered	Not considered	Not considered

Source: Hamali (1999)

By drawing on the concept of quality management literature, there are formal evaluation models or standardized quality models utilized by organizations in order to assess their implementation or as a director for their quality practices. A large and growing body of literature has investigated that several Quality Awards have been developed in the world; however, the most accepted domains and universal actions in this area are the Malcolm Baldrige National Quality Award in the United States of America, the European Quality Award (EFQM) in Europe, the Deming Prize in Japan, and other similar awards in other countries. However, according to literature review, quality awards have not developed in Middle East, and particular in Iran.

2.2.2. Framework of Quality Management

Quality management (QM) is usually referred to as total quality management (TQM) (Stashevsky and Elizur, 2000). Quality management practices (QMP) as a whole includes those that are connected to total quality management based approaches. It is important to note that the QM practices taken in this study are termed as critical success factors of TQM that can help organisation to attain business excellence (Talib and Rahman, 2010). Moreover, published literatures are available on QM practices adopted by different practitioners and academicians in different service industries. Since we are not trying to highlight any major difference between the two terminologies (i.e. QM and TQM) so we have used these terms interchangeably as often has been done by several scholars like Lakhal et al. (2006); Fening et al., (2008); Kim et al., (2012); Ebrahimi and Sadeghi, (2013); Parvadavardini et al., (2015). It is also important to note as cited by Ooi et al. (2011) in Journal of Services Marketing that the most commonly used method by scholars to research and study on the quality management principles of an organisation is through the use of TQM constructs. Throughout the years, TQM dimensions have been widely used by many well-known scholars, such as Flynn et al. (1994), Terziovski and Samson (1999) and Prajogo and McDermott (2005) for the study of quality management and theory.

2.2.3.1. Defining Quality Management

Numerous studies have attempted to define quality management (QM) making it have some constancy in its definition in the academic literature over time. Wacker, (1998,

2004) suggests that a suitable meaning of quality management should be based on past concept. Quality management was defined by Snell and Dean (1992, p. 470) as a management method that can *"be characterized by a few basic principles as well as a number of associated practices."* Dean and Bowen (1994) defined QM as a *"philosophy or an approach to management"* made up of a *"set of mutually reinforcing principles, each of which is supported by a set of practices and techniques"*. In addition, a number of findings have found that the basic philosophies of QM commonly are comprised of teamwork, process and customer focus (Dean and Evans, 1994; Evans and Lindsay, 2011).

A large and growing body of literature has investigated diversity of methods employed for QM, from the philosophical notions to particular practical approaches. A considerable amount of literature has been published on QM; the notion of distinctive levels is broadly utilized in the literature of QM. Hellsten and Klefsjö (2000) differentiate three stages of QM: tools, methods and principles. Additionally, Lagrosen and Lagrosen (2005) investigate three levels of QM components, however, they title them a little differently: techniques and tools, values, models and approaches. There is a large volume of published studies distinguishing three principals and most widespread models to QM in scientific literature: Total Quality Management (TQM), Quality Management System (QMS) and European Foundation for Quality Management (EFQM). However, total quality management referred to as quality management is commonly accepted as a method to organizational management.

2.2.3.2.Total Quality Management

An organisational definition of Total Quality Management cited by Goetsch and Davis (2013, p. 4) is *"[...] doing the right thing right the first time, always striving for improvement and always satisfying the customer"*.

A considerable amount of literature has been published on Total Quality Management. These studies have broadly accepted that Total Quality Management is an integrated management philosophy (Tambi, and Kanji, 1999) intended at constantly developing the performance of processes, services, and products in order to surpass and achieve customer prospects (Karpak and Bayazit, 2007).

Total quality management (TQM) – total quality management is management philosophy that improves the constant development integrating all workers into action to increase the level of customers' satisfaction. TQM is an extremely broad notion comprehended as management approaches that prompt the company to develop constantly (Vanagas, Vilkas 2008; and Grundey 2008), involving all the workers in such procedure and making sure the superiors meet the requirements of customers, developing quality of the product, and decreasing expenditures (Bendell et al. 2000, Dale et al. 1994, Hellsten, Klefsjö 2000).

Goetsch and Davis (2006) suggest that there are eleven critical components of TQM: Customer Focus, Long-term commitment, Education and Training Scientific approach, strategic Obsession with Quality, Continual Process Improvement, Teamwork, Freedom

Through Control, Employee Involvement and Empowerment, and Unity of Purpose. As noted by Basu (2004), the philosophies of quality development are planning and reducing cost. Lagrosens et al., (2005) undertaking to examine the systematic literature, recognizes six core total quality management philosophies repetitive in numerous quality management frameworks: Process orientation, Continuous improvements, Customer orientation, Leadership commitment, and Management by facts and Participation of everybody.

Hashmi defined Total Quality Management as (2004): *"Total Quality Management is a management philosophy that seeks to integrate all organizational functions to focus on meeting customer needs and organizational objectives"*, whereas Powell described it as an organizational culture mandated to satisfy customers through continuous development, or as the procedure of making quality the concern of each individual in the company. According to Ennis and Harrington (1999), these two definitions stress the significance of multidisciplinary collaboration as a fundamental requirement of total quality management. In their theory, they imply that every team member has an equal responsibility to play in the delivery of patient care. This leads to create a cross-functional method where no single department or individual, is superior to another.

While numerous studies have defined total quality management and there are numerous definitions of Total Quality Management, what actually makes it difficult for the top management to employ the essential notions is its specific business situation.

Anderson and Lua (1998) present a basic digest of the core factors of Total Quality Management from which a meaning can be made, as indicated in Table 2.2.

Rohaizan & Tan (2011) claim that total quality is a broader notion that encompasses not only the result but also the quality of people and processes. Rohaizan & Tan (2011) suggested that definitions of total quality management be divided into two classifications: in terms of functions and practices and in terms of its goal. In addition Kanji (1999) describes Total quality management *"as a way of life in which an organization is committed to customer satisfaction through continuous improvement*". Dale (1994) describes total quality management as *"the mutual teamwork of everyone in an organization and associated business process to produce products and services, which meet the needs and expectations of the customers"*.

Berry et al., (2006) defines the TQM process as *"a total corporate focus on meeting and exceeding customers' expectations and significantly reducing the costs resulting from poor quality by adopting a new management system"*. Whereas, total quality management is defined *by* Juran and Gryna (1993) as *"a philosophy aimed at achieving business excellence through the use and application of tools and techniques, as well as management of soft aspects, such as human motivation in work"*.

However, there are numerous definitions of total quality management, what is exceedingly a problem for leadership is to employ the essential views in a method suitable for its specific business situations. As indicated in Table 2.2, Lua and Anderson

(1998) provided a simplified summary of the key factors of total quality management from which a classification can be formed.

Table 2.2: The Major Elements of TQM

Total (T)	Quality (Q)	Management (M)
Need Employee Participation and Teamwork	External and Internal Customer Driven	Prerequisite Duty Top Management
Each Individual must Improve a Sense of Quality Possession	Stress on Continues Development	Setting Goals and Values for the Organization
Engage all Level and Purpose in the Organization	Technical Issues: Training for Skills and Knowledge	Leadership is Critical
Employ System Thinking	Human Matters: Support Novelty	Create Suitable Transformation in Culture of Organizational

Source: Lua and Anderson (1998)

Quality Management System (QMS) is a management method directing business activity to fulfill the quality as demanded in ISO 9000 (Pociute et al. 2004; and Bass, 2004). Many scholars hold that the purpose of implementing quality management system is to coordinate all progressing procedures in business in order to achieve superior outcomes, thus its ultimate outcome would create the enterprise the desired profit and finally satisfies client requirements (Pociute et al. 2004; Bass, 2004; and Goetsch et al. 2006).

Oakland (2003) holds that the intention of implementing a proper quality management system is to guarantee the recognition of an organization's objects stated in its quality policy. However, some writers have defined quality management system as a structure for applying a quality programme, and stress the significance of attaining constancy across launching a quality system in the company. Dale (1999) for instance claims that the main intention of a QMS is to found a structure of reference points, to confirm that every time a procedure is accomplished, methods, skills, the same information and controls are utilized and implemented continually. Likewise, Ivanovic and Majstorovic (2006) highlight that a QMS is an approach for the development of effectiveness and efficiency in institutes, whereas Poksinska et al. (2006) propose that a quality management system relates to the system of procedures by which the service and produce is improved.

Drawing on an extensive range of sources, the authors have investigated different formal evaluation models or standardized quality models utilized by organizations in order to carry out self-assessments of their quality practices or as a guide for their implementation. A considerable amount of literature has been published on standardized quality models. There are numerous Quality Awards in the literature review, however, the most acknowledged domains and universal actions in this ground are the Malcolm Baldrige National Quality Award in the United States of America, the European Quality Award (EFQM) in Europe, the Deming Prize in Japan, and other similar prizes in other countries.

Each award model is based on a perceived model of TQM. The award models do not focus solely on either product or service perfection or traditional quality management methods, but consider a wide range of management activities, behaviors and processes that influence the quality of the final offering. These models provide a useful framework through which firms can evaluate their TQM implementation practices; seek improvement opportunities, and the end results.

It has been suggested that these quality award models a universal module for estimating features of total quality management practices in an organization (Sila, 2007). While all quality award models have their unique classifications and stress, there are several shared parts: (1) Each quality award model has two parts: Total quality management enabler and generally business outcomes, (2) Most of these quality award models highlight the significance of process management, employee relations, leadership, supplier quality management, information, customer focus, and policy and strategy.

Some authors have criticized (Anderson, and Leavengood, 2011) inadequacies of quality award models shortage of a united approach to describe how organizational results are attained, shortage of reliability, and shortage of strategic focus which is not surprising because business excellence models have been promoted and improved by specialists.

A large and growing body of literature has investigated the relationship between the total quality management implementation and the boundary of ISO 9000 standards

(Quazi et al, 2002; Magd and Curry, 2003). As Laszlo (2000) noted total quality management and ISO 9000 standards are completely dissimilar methods in which ISO 9000 application is related to line operatives and total quality management associated with to top management. Moreover, ISO 9000 standards offer merely compliance through examining and accreditation as different to a fundamental method to all features of the all industry (Barnes and Stevenson, 2001). However, Najmi and Kehoe, (2000) state total quality management implementation stresses continued development and achieving customer satisfaction not essential to any given assessment standard. As Dale (2003) highlights total quality management is much wider than an official assessment method and not much can be identified through such assessments. Consequently, they believe that a systematic method is required to direct all feature of the organization if total quality management is to be attained, and just having ISO 9000 standards is not sufficient to attain total quality management. Some authors have realized the weaknesses of ISO 9000 standards. The new version of the audit has combined total quality management philosophies to match all benchmarks (Beckford, 2002). This leads the business institutions to deem quality management as their means to their success.

2.3. Analysis and Selection of Quality Management Contexts

A large and growing body of literature has been carried out to choose total quality management and quality management contexts for this study. A number of studies into QM/TQM have recognized numerous critical success factors (CSFs) that influence an organization's situation. In recent years, there has been an increasing amount of literature on QM critical success factors; however, very few writers have empirically validated the

QM CSFs or used some factors (Ahire et al. 1996, Saraph et al. 1989, Flynn et al. 1994, and Powell 1995). According to quality leader, several QM implementation studies and quality awards exist in different countries, based on the writings of Crosby, Ishikawa, Deming, Feigenbaum, and Juran. There are four most important quality awards in the world: the Deming Prize, the Malcolm Baldrige National Quality Award (MBNQA), King Abdullah II Award (Jordan), and the European Quality Award (EFQM).

To develop the framework of the research, six quality management practices have been selected (Ahire et al., 1996; Saraph et al., 1989; Flynn et al., 1994; and Powell, 1995. Based on frequency analyze, the critical success factors quality management practices are presented in Table 2.3 to the Analysis and select of quality management framework.

Table. 2.3: Analysis and Selection of Quality Management Context

Authors / QMPs Factors	Customer focus	Employee Relations	Leadership	Process Quality Management	Strategic Planning	Supplier Quality Management
Ahire et al. (1996)	1	1	1	1		1
Anderson et al. (1995)	1	1	1			
Black & Porter (1995)	1	1	1	1	1	1

Crosby (1979)		**1**	**1**	**1**	**1**	**1**
Deming Prize	**1**	**1**	**1**	**1**	**1**	**1**
EFQM(European Quality Award)		**1**	**1**	**1**	**1**	**1**
Feigenbaum (1991)	**1**	**1**	**1**	**1**	**1**	**1**
Flynn et al. (1994)	**1**	**1**	**1**	**1**		**1**
Ishikawa (1985)		**1**	**1**	**1**		**1**
Ismail (2006)	**1**	**1**	**1**	**1**	**1**	**1**
Juran (1988)	**1**	**1**		**1**	**1**	**1**
Kaynak & Hartley (2005)	**1**	**1**	**1**	**1**		**1**
King Abdullah II Award for Excellence		**1**	**1**	**1**	**1**	**1**
Malcolm Baldrige Award (U.S.)	**1**	**1**	**1**	**1**	**1**	
Prajogo & Sohal (2006)	**1**	**1**	**1**	**1**	**1**	

Rao et al. (1999)	**1**	**1**	**1**		**1**	**1**
Samson & Terziovski (1999)	**1**	**1**	**1**	**1**		**1**
Saraph et al. (1989)		**1**	**1**	**1**	**1**	**1**
Sureshchandar et al. (2001)	**1**	**1**	**1**			
Tarı´ et al. (2007)	**1**	**1**	**1**	**1**	**1**	**1**
Xingxing Zu (2009)	**1**	**1**	**1**	**1**		**1**
Zhang et al. (2000)	**1**	**1**	**1**	**1**	**1**	
Deming (1986)	**1**	**1**	**1**	**1**	**1**	**1**
ISO standards	**1**	**1**	**1**	**1**	**1**	**1**
Powell (1995)	**1**	**1**	**1**	**1**	**1**	**1**
Sila &Ebrahimpour (2005)	**1**	**1**	**1**	**1**	**1**	**1**
Agus et al.	**1**	**1**	**1**	**1**	**1**	**1**

(2009)						
Sila (2007)	**1**	**1**	**1**	**1**	**1**	**1**

Thus, the following six critical success factors have emerged out of a beyond analysis and the most regularity in quality management studies. These basics of quality management practices are: leadership, customer focus, strategic planning, employee's relation, supplier management process management quality, and results. The critical success factors of quality management practices are listed in table 2.3.

The next section provides a brief description of each construct of quality management practices.

2.3.1. Top Management Support (Leadership)

Many scholars hold that a critical success factor is 'top management support'. Most researchers (Saraph et al., 1989; Flynn et al., 1994; 1995; Ahire et al., 1996; Juran, 1988; Anderson et al., 1995) believe that strong responsibility from the senior management is fundamental in QM besides leading a superior quality performance.

It is believed that top management performances is the driving force of implementing QM, guaranteeing goals, values, and schemes to content customers' expectations and develop structural presentation (Ahire et al., 1996).

Juran & Gryna (1993) identified the responsibilities of leadership as: deploying quality goals, establishing quality policies, offering problem-oriented training,

developing and providing resources. According to Anderson et al. (1994) the notion of top management is described as: the capability of leadership to ascertain a practice, and lead a long-term vision for the organization, focusing on meeting the customers' needs.

Consequently, the evidence presented in this section suggests that the top management element is associated with the ideas that QM leadership assumes quality accountability; makes goals and strategies for quality; participates in quality improvement efforts; assesses the quality; arranges IS strategy with business strategy; organizes performance and productivity, and considers consumers requirements (Saraph et al., 1989; Flynn et al., 1994, 1995; Ahire et al., 1996; Rao et al., 1999; Sila & Ebrahimpour, 2005; Wilson & Collier, 2000; Anderson et al., 1995; Black & Porter, 1996; Crosby, 1979; Deming, 1986; Juran & Gryna, 1993; Kaynak, 2003; Powell; 1995; Prajogo & Sohal, 2003).

It is suggests that leadership in the sense of top management is important in influencing groups of people and mobilizing resources. According to Sila & Ebrahimpour, (2005) effective leadership promotes the strategic direction of the organization to achieve customer satisfaction and business results. The leadership theory will be discussed in chapter 3.

2.3.2. Customer Focus

A number of studies have found a strong connection between the transfer of high quality services and products and productivity throughout satisfying customer needs (Sila & Ebrahimpour, 2005).

Customer satisfaction is defined by Anderson as the measure to which a firm's customers continually perceive that their needs are being met by the firm's products and services (Anderson et al., 1994). It has been suggested that a company must recognize Customer connection to the degree of customer requirements, include customers in quality development; and guarantee customers' satisfaction (Prajogo & Sohal, 2003; Sila & Ebrahimpour, 2005; Flynn et al., 1994, 1995; Powell, 1995; Ahire et al., 1996; Black & Porter, 1996).

Previous studies have stated the significance of customer satisfaction. Deming (1986, p. 32) states: *"The consumer is the most important part of the production line. Quality should aim at the needs of the present and future consumers"*.

2.3.3. Strategic Quality Planning

Juran & Gryna (1993,) defined the concepts of strategic quality planning as: *"Strategic Quality Planning is a structured process for establishing long-range quality goals, at the highest levels of the organization, and defining the means to be used to reach those goals"* (p. 300). Moreover, strategic quality planning is defined by Krumwiede & Charles (2006, p. 37) as *"the strategic aspects of quality are recognized and embraced by top management in the strategic planning process"*.

Consequently, there is evidence proving that strategic quality planning lets organizations to establish priorities and assign resources for the significant items.

According to Sila & Ebrahimpour, (2005) the emphasis of a QM expert involves a top management's vision of an institution's desired future state, converting vision into plan, objectives and strategy, and strategy improvement.

2.3.4. Employee Relations

Many scholars referred to the significant of workforce management element to attain the goals in organizations. It stresses on identifying staff performance on quality; offers training; supports teamwork; and engages workers in quality decisions (Saraph et al., 1989; Kaynak, 2003; Prajogo & Sohal, 2003; Anderson et al., 1995; Flynn et al., 1994, 1995; Powell, 1995; Ahire et al., 1996; Black & Porter, 1996; Wilson & Collier, 2000; Sila & Ebrahimpour, 2005).

Previous research findings in the human resource show employee relation and training were positively correlated to quality development. Available literature seems to support the view that a total quality management schedule to be effectively applied depends on the coordination among an organization's staff (Ho et al., 1999). Ahire et al., (1996) also suggested workers' additional responsive decisions to customers can have a positive effect on customer relations through boosted access to resources and information.

Previous studies (Flynn et al., 1995; Deming, 1986; Kaynak, 2003; Ho et al., 1999; Ishikawa, 1985; Ahire et al., 1996) have reported that involving all workers in making constant development is fundamental under such situations. It has been suggested (Kaynak, 2003; Anderson et al., 1995; Flynn et al., 1995; Rao, Solis, & Raghu-Nathan,

1999) that the organization must make sure that an organization-wide training schedule is accessible in order to deliver staff with the appropriate services.

2.3.5. Supplier Quality Management

There is very strong evidence that the supplier quality management is a significant factor of QM in the institution since the purchased parts and materials are a main basis of quality problems (Kaynak, 2003; Flynn et al., 1994). Previous studies have reported that supplier relationship puts emphasis on: containing suppliers in product improvement; relying on a small number of suppliers; offering training and practical support to suppliers; and estimating suppliers based on quality (Saraph et al., 1989; Kaynak, 2003; Sila & Ebrahimpour, 2005; Anderson et al., 1995; Powell, 1995; Ahire et al., 1996; Flynn et al., 1994, 1995; Black & Porter, 1996).

It has been suggested that (Feigenbaum, 1991; Ishikawa, 1985) the organizations select their suppliers based on the foundation of quality and not on price. For example, Deming (1986) believes that the cost has no sense without an assessment of the quality being bought.

According to Kaynak, (2003), supplier quality management improves the collaboration between organizations and suppliers through allowing suppliers' participation and involvement in the plan procedure and in the construction procedure (Flynn et al., 1995; Kaynak, 2003). Suppliers' management can help the procurements of resources meet the organization's needs and make sure they are proficiently used.

2.3.6. Process Management Quality

Several studies have reported (Anderson et al., 1995) the value of process management application as one of the main elements of incorporated quality attempts. Therefore, there is very strong evidence that the process includes combinations of methods, tools, resources, and workforces engaged in production.

Scholars suggested (Flynn et al., 1995; Anderson et al., 1994) that the aim of process management is to decrease procedure difference through constructing quality into the production procedure. Consequently, it leads to improving the quality of outcomes and reducing the expenditures such as waste expenditures and rework expenditures (Anderson et al., 1994; Forza & Flippini, 1998). According to Deming (1986) developing product quality would not be related to mass examination. He also believed that Quality originates not from examination, but from development of the production process.

The EFQM Excellence Model (EFQM, 2010; KAAPS, 2010) defines the process management as *"how the organization designs, manages and improves its processes in order to support its policy and strategy and fully satisfy and generate increasing value for its customers and other stakeholders."* The Malcolm Baldrige National Quality Award (MBNQA) standards categorize the process of management classification in *"the central requirements for identification and management of core competencies to achieve efficient and effective process management"* (NIST, 2010).

Therefore, there is very strong evidence that almost all principles of QM cited in systematic literature are linked to other management approaches: operations management, quality management performance, management accounting, marketing, and management of human resources.

Based on what has been said so far, total quality management and quality management systems involving all QMSs are utilized as contexts to incorporate all organisational activities and functions in order to meet organisational objects, support continuous development, and make sure to satisfy customer's requirements.

Therefore, the principles of QM are studied in scientific literature extensively, mainly concentrating on the six core principles of QM and impressive attention is paid to procedure orientation. There is not enough evidence about how to implement QM, the effective factors in implementation of quality management, especially the role of leadership in implementation of quality management.

Many scholars (Foster 2007; Pociute et al. 2004; Vanagas 2004) suggested that in order to assess the implementation level of QMS, the QM principles be utilized: world-class W. E. Deming the European Quality Award (EFQM) model or Malcolm Baldrige quality awards (MBNQA). The evidence presented in this section suggests that the analysis of incorporated factors of these award quality models illustrates that principles of QM are mainly taken into consideration in Quality Award (EFQM) model and the Malcolm Baldrige National Quality Award (MBNQA), leastwise – in Deming prize needs.

Together, these points provide an important insight into the implementation of QM principles. The evidence presented in this section suggested that organizations need information about how to implement QM comprehensively to reach the highest profit.

2.4. Implementation of Quality Management

A large and growing body of literature has investigated QM implementation. Hence, as Macleod and Baxter (2001:392) states: *"despite the enthusiasm shown for the approach and well-publicized reports of successful applications, there are substantial data confirming the failure of some up to 80 per cent"*. This suggests that an effective implementation has its specific method in terms of progression and substance. Successful constant development performances in Japanese institutes have persuaded numerous organizations to reevaluate the QM approach presented by Deming *"Its widespread popularity appears to stem from numerous case studies attributing organizational turnaround to the influence of the Deming management method"* (Anderson et al., 1994). The concept of the Deming approach emphasizes the process management, which is fundamentally maintained by the organizational scheme to develop organizational efficiency. Subsequently, companies in different countries implement 'me too' mindsets for implementing their schedules (Benner and Tushman, 2003). According to the Japanese improved model of organizational superiority, the organizational-oriented QM model contains three factors: organization and management, education, and corporate policy (Hardjono and Bakker, 2001). This implies a change in experiential practices: from operative attainment across autonomous collaboration in practical discreteness to organizational efficiency through dependent teams (Hardjono and Bakker, 2001). In

MBNQA and EFQM models, leadership is the main enabling factor whereas in the Deming Prize model, corporate policy is the main enabling factor. However, the literature on QM has gradually developed identifying (Benner and Tushman, 2003) the organizational-oriented QM models do vary in method and scope. The organizational-oriented QM models share a concentration on process management, which involves coordinating the improved processes, measuring, and developing. The evidence presented in this section suggests that process management is fundamental for constant arrangement of quality management (Hardjono and Bakker, 2001).

2.4.1. The Complexity in Implementing Quality Management

According to Hammer (1996), QM is a process-based management technique, whose emphasis is on process management. Process management activities are defined by Benner and Tushman (2003) as mapping, reforming, and clinging to the developed procedures. The developed process management makes improvement in terms of performance and reaction. It has been suggested that the improvement includes the contingent effects of organisational structure and environmental circumstances (Benner and Tushman 2003). According to Harten et al., (2002), studies on managing the complexity of QM implementation are inadequate. It has been suggested that the implementation procedure be realised as the main problem in introducing new tools or methods into an organization (Harten et al., 2002; and Ruel, 2001). According to these research studies, comprehensive implementation is recognized across a deep assessment of the process of transformation of principles and concepts into practices appropriate for the organisational features and environment. It has been suggested (Van de Ven and

Huber, 1990) that implementation not merely concern itself with attaining effectiveness based on an input-process-output model. Consequently, any argument on implementation of QM must take viewpoint into account. Furthermore, identifying the role of leadership in this change (implementation of quality management) is required which is the main focus of this research and also the effecting factors in implementation of quality management.

2.4.2. Implementation as a Process of Change

A large body of literature highlights that the term *"process"* is used as a management approach (process-based method, process management, process orientation,), a methodology (a structuration process), a flow of performances (the process of production), and a factor of implementation (content process, and context). Recent evidence suggests that in implementation of QM, a procedure of change be also studied as a recursive process of change is created and improved.

Several research studies have investigated that the process of change in implementation of QM involves the evolution, improvement, and formation of a QMS, the internalization of the procedure into performances, and the development of the procedure. The process of implementation is characterized by Taylor (1996) as a cycle of initiation, adaptation and adoption. He believes the process of implementation, such as in improving QM, is introduced by building incentive and the institutionalization of patterns and mindsets in whole components of the organization, prior to the operationalization of procedures, approaches, and instruments. It has been suggested (Hill et al., 2001) that the

initial stage involves building motivation, evolving the mindset, attaining understanding and building motivation. Consequently, it has been argued (Lindsay and Petrick, 1997) that integrating the appropriate viewpoints containing contingencies of the environment is essential. Since progression continues, scholars develop the following procedure of implementation across a variety of viewpoints, e.g. setting up new ideologies for continuous improvement (Imai, 1997; Savolainen, 1999), socio-dynamic interactions (Harten et al., 2002), and knowledge building (Nonaka and Takeuchi, 1995). According to literature review, in this progress, effective environmental elements have not been constantly studied as set contingencies. The affecting environment may be totally novel or a consequence of reforms of the current situation. Numerous studies have explained expressions of essential shift as, radical change, transformation, and total change.

Traditionally, it has been argued (Pettigrew, 1997) that implementation is supported through specific settings of 'how the organization actually works' and 'what the organization actually does'. Similarly, Reed et al. (1996) state the "*what*" and the "*how*" correspond with the procedure of implementation of QM and demonstrations of the content. Daft and Lewin (1993) believed that the correlated connection between these two questions indicates the constancy between the practical relevance and the design issues. Accordingly, QM implementation can be considered as a procedure of continual structures of construction across activities (Barley, 1986). However, this structure requires developing perspective on implementation.

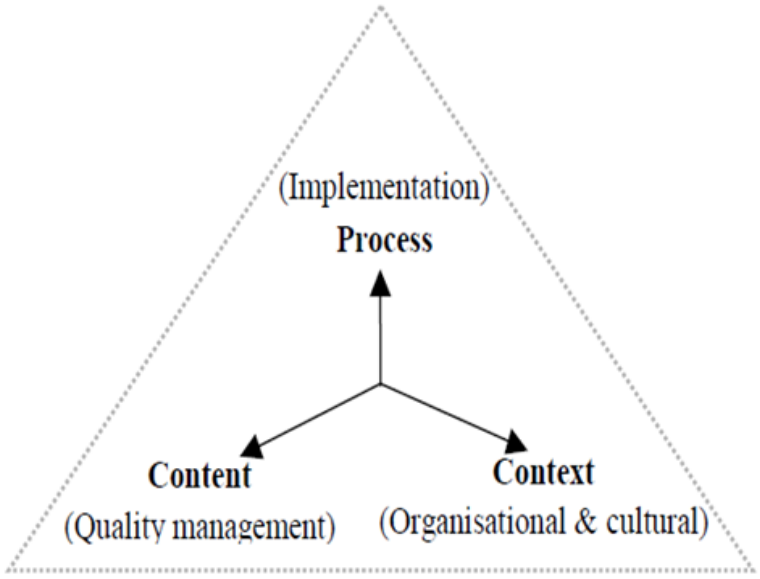
This view (developed perspective on implementation) holds that values determine the acceptance of the quality management philosophies in practice. Then, adverse adapted practices are institutionalized into daily affairs (routines), and subsequently the routines introduce a new set of values. This mechanism involves process (*how*), contents (*what*), and the influence of context (*why*). Barley (1986) suggests this recurring mechanism of interaction between structure and action be called *"sequential model of structuring"*. Based on this view the process of implementation does not form the firm straightforwardly in a rational method of fit between cause and effect. It is probably integrating the development of several features in a sequence of activities. The development of the elements of quality management, through implementation, requires being suitable to the existing principles and values, and then developing the philosophy and values become part of the implementation process.

In 2001, Hardjono et al. published a paper in which developing the basic principles and values of QM can be recognized by two methods: the practical programmes and the value first. Many organizations intensely utilize practical programmes. Therefore, organizations emphasize on acting performances with concrete continuity and disintegrated outcomes to generate a vision that is socialized into the company by managerial, cultural and technical representations. According to the study of Pettigrew (1997), the implementation of quality management is considered as a process of change, the context of the organization and the internal content are shaped simultaneously or interchangeably.

Available literature seems to support the view that consideration of context may also implicate the contingency influence of the environment. According to Barley's model of constructing, implementation of QM not merely contains collaboration between the substance of QM and performance to progress this substance, but also the effect of context in forming the substance and in managing the performance (1986). Based on what was already said, implementation of QM is considered as a multidimensional change. Subsequently, according to Pettigrew and Whipp (1991)*"three essential dimensions of change"*, the dimensions of implementation of quality management can be structured as comprising of the content, the context and the process, as illustrated in Figure 2.1 in which the arrows signify the relations between these dimensions.

The three dimensions of quality management implementation

Based on Pettigrew and Whipp, 1991



2.4.3. The Content of Quality Management

Many scholars (Reed et al., 1996) claim that the content of QM influences the act directly or indirectly and the capability to compete. Based on a comprehensive literature review, defining the content of QM is extremely related to the definition of quality. The different meanings of quality, reviewed above, have their influences on magnitudes and scopes that lead common individuals to only describe quality across measureable indicators such as price, market share, and cost. Drawing on the management literature, the extension of the coverage from a production procedure to society guarantees the concept of quality orientation, they describe the QM content. Concerning this extension, the Dutch Quality Institute (INK) describes the classification of QM orientation to measure the level of quality accomplishment of an association for the Dutch Quality Award (DQA). In fact, the measures of accomplishment are grown based on the (EFQM) European Foundation for Quality Management. It has been suggested that QM content comprise both action and structure. The components of the model signify the content as structures, whereas the correlated quality management actions are rooted in each component and in the interactions between components. Based on the literature, the European model is similar to other models in quality management excellence, e.g. the Malcolm Baldrige National Quality Award model (the USA), the ISO 9000 quality assurance model and the Deming Prize model (Japan). Overall, the components of these models highlight the content of QM, and these components are acknowledged and partly customized in national quality models in various countries.

2.4.4. The Context of Quality Management

Since the content of quality management develops into the ideal orientation, implementation quality management significantly introduces new ways of thinking to organization. This introduction takes place since implementation quality management *"includes changing the way people interact and work in an organization"* (Tata and Prasad, 1998). Introduction of new ways of thought means that implementation is affected by related context and culture either directly or indirectly. The literature shows culture of an organization and an individual as an influential context for implementation. For instance, the element of QM implementation is a manifestation of a culture, and culture is infrequently regarded as the reasons behind the success (or failure) of an implementation. (Sigler and Pearson, 2000). There is a relationship because implementation of quality management *"embodies a set of values and behavioral standard that contain many fundamental components of cultural system"* (Jenner et al., 1998).

Culture can be classified as agreed or unstable, as a context of implementation. Culture turning into *"one of the most powerful and stable forces operating in organizations"* (Schein, 1996). If the context is given, an organization visions the essentials of culture as a basic orientation in implementation of QM. If the context is changeable or flexible, an organization can develop appropriate characters of practices, and then adjust these into routines. If these routines are helpful in quality management of implementing, they can be institutionalized as new principles. Connected to these visions, the literature introduces the terms of organizational culture and national culture. However, this does not mean that national culture is always inflexible and organizational

culture is always flexible. The point is the organizational culture is always subordinate to national culture.

2.4.4.1. National Culture as a given Context of Implementation

Implementation of quality management is frequently targeted by successful practices in an organization in one special country. *"It worked in Japan so why does it not work here?"* This has been an instance of common express at whatever time an association attempts to implement an idea directly concerning quality or process management from Japan, like quality control circles which are highly affected by Japanese culture. The requirement to perceive quality management from a cultural standpoint needs one to admit the cultural dissimilarities. Deming (1993), for instance, extended a theory of management acknowledged as *"a system of thoughtful (profound) knowledge"* that has been indicated to be appropriate to any culture. However, Deming remarks that the application of this theory in a society will be liable to be restricted to issues that are exclusive to character of culture of that society. In other words, it means that concentration on specific features of a culture is inescapable. Though no commonly acknowledged characteristic of a culture fits all. Concerning country differences, culture as the context of implementation can be described rather polycentric than ethnocentric. Ethnocentricity is based on norms and values of an individual participant, whereas polycentricism incorporates norms and value from different participants. The participant can be a group of individuals or an individual.

Studies regarding national culture as a context have situated an organization in one country corresponding to organizations in other countries in terms of differences and similarities. Although, according to Hofstede, (1991) there is no agreement regarding the definition of culture, it can be defined as a set of shared values, practices and norms, or collectively as an incorporated pattern (of human knowledge, belief, and behaviour) that depends on human capacity for learning and transmitting knowledge to succeeding generations. Hofstede (2001) defines five scopes of national culture founded on the collective insight of individuals, i.e. *uncertainty avoidance, power distance, time orientation, masculinity-femininity*, and *individualist-collectivism*. These dimensions make the collective programming of the mind discriminate the participants of one group from another. Schein (1992) states that original cultural configuration is a capability to contribute to including learning and comprehensiveness of a *"common language"*. Recent collective practices have commenced the formation of a new culture as a feature of a specific group. Consequently, an organization tends to be unified. According to Parker (1993) there are further ways of thinking about culture and organizations proposing that organizational cultures ought to be perceived as fragmented unities' in which the followers recognize themselves as collective at some times and separated at others and thus the decision for adoption of norms and values are more facilitated. This dispute leads to the significant role of organizational culture.

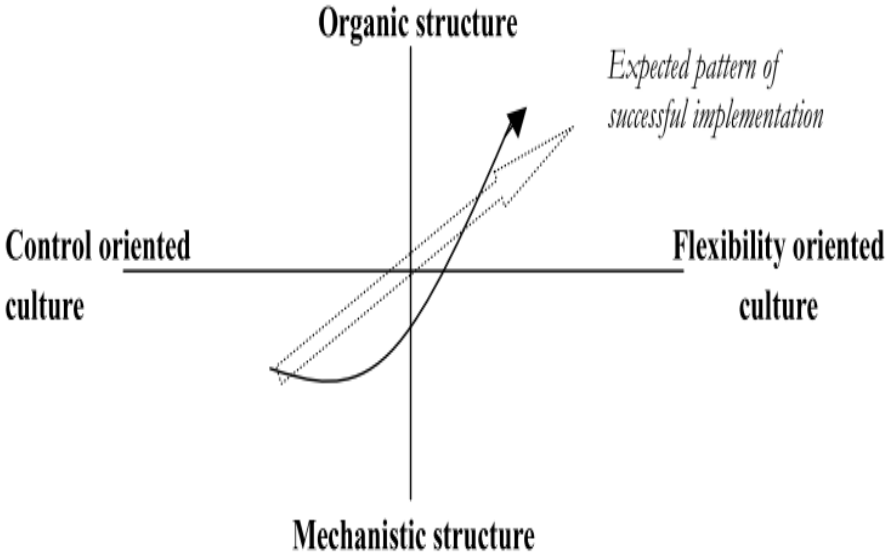
2.4.4.2. Organizational Culture as a Flexible Context of Implementation

According to Hofstede et al., (1990:286) the culture of an organization can be considered as having *"obtained a status similar to strategy, structure and control"*. , Two

different descriptions are frequently utilized in organizational culture philosophy (Kekale and Kekale, 1995). At the outset, the organisational culture relates to a set of coherent basic norms that exclusively symbolize a group and rules and its preferences. Furthermore, being a set of characteristics represents not only a basic value, but also the models of behaviour, symbols and beliefs. This implies that managerial style is a result of culture being easily examined through management practices. But the meaning of culture as an expression of symbols, heroes and rituals is still invisible (Hofstede, 2001). Hofstede (2001) contributes to the formation of dimensions of organizational culture, that is, open-closed parochial-professional, process-result, loose-tight, pragmatic-dogmatic, employee-job and enabling clarification of the circumstances supporting the practices of individuals in an organization.

Hofstede (2001) believes that two dimensions of national culture, i.e. uncertainty avoidance and power distance are directly linked with organizational value orientation (control and flexibility) and structures (mechanistic and organic) which are the basis for constructing an establishment in the formation of flexibility and the degree of formalization in organization. Similarly, Tata and Prasad (1998) recognize that these two dimensions are significant in quality management implementation. They present a model related to culture and structure of implementation of QM including a control-flexibility oriented culture and a mechanistic-organic structure, as illustrated in Figure 2.2. A flexibly oriented culture and an organic structure match up with success in implementation of quality management.

2.2 The link between culture and structure and implementation success



Source: Tata and Prasad, (1998)

From a different viewpoint, Trompenaars and Hampden-Turner (1997) suggested four types of shared cultures within dimensions of parity of hierarchy (hierarchical as opposed to egalitarian) and orientations towards persons and tasks. Within these dimensions, an organization is characterized as (i) *"guided missile"* (an egalitarian-task and person oriented), (ii) *"Eiffel tower"* (hierarchical-task oriented) (iii) *"family"* (hierarchical-person and role oriented), and (iv) *"incubator"* (a democratic and project oriented). An organization is not constantly associated with only one type of organizational culture; it can be reflected in two types, however, not ones in diagonally opposite quadrants.

2.4.4.3. Change of Culture as an Impact of Implementation

According to Cartwright, (1999) cultural change contains the (re-)organization of principles, behavioral norms, attitudes, and management style. Interior pressure is not the only resource initiating cultural change. For instance, a change of outlook affecting the way of viewing a problem is a helpful plan in overcoming a problem. A way to initiate cultural change is diffusion and communication in order to realize a general understanding of new or successful practices. According to Cartwright (1999), who continues by listing conditions, development can be signified by a measurable attitude based on the condition of acceptable values and beliefs. With dissimilar acceptable values and beliefs, the answer to new or successful practices could be dissimilar. In the beginning, an instance of a suitable practice supplies a good outcome. Recognizing this outcome advances support towards comprehension. Then, incentive to recur the same pattern was built, and expressed in willingness to be incorporated and mutual distribution. All these procedures can only be accomplished by winning over ‘minds and hearts’ of individuals.

Furthermore, Bate at al., (2000) believed that diffusion and communication are essential, however, not adequate for cultural change. Organizational culture can be regarded as a process of continual structure through interventions and interactions, in the perspective of change (Bate et al., 2000). Organizational culture can be regarded as a procedure of continual structure through interactions and interventions (Bate et al., 2000). According to Tenner and DeToro, (1992) introducing QM principles for instance a focus on customer satisfaction and continuous development can be seen as redefining the held

value system of an association as a result of following superior organizational effectiveness. The role of the main group is essential in mediating the organization. Hofstede (2001) believes interventions and interactions as reinforcement, through feedback mechanisms, from the consequences to the origins and the societal norms. It is significant to mention that organizations require comprehending how to implement quality management to attain the maximum benefit.

2.4.5 The Process of Quality Management Implementation

The variance-based method produced a discrete result that doesn't occur if either the circumstances or their order change. However, the process-based approach constantly produces a result unless in specific conditions.

In observing an implementation, either a process-based or a variance-based method may be utilized. The process-based method produced a discrete occurrence of a result that may not occur while circumstances exist, unless in specific sequence containing probabilistic occurrences unfolds. The variance-based approach makes a result variable constantly happening while sufficient and necessary conditions are present in any order (Mohr, 1982). Both methods classify particular research in the field of organization. In the field of implementation of quality management research using the difference approach aiming to find the significant success factors. The key goal of research study utilizing the variance method is predicting the effectiveness or result founded on presumed relationships and conditions of factors being relevant to the success implementation.

Accordingly, the subsequent subsections discuss the critical factors and also the problems and obstacles with the implementation of quality management, the organizational and managerial perspectives of the implementation process, and the process approach to implementation.

2.4.6. Critical success factors for Implementing Quality Management

Critical success factors (CSFs) are the factors fulfilling the successful quality management implementation mentioned above. Numerous research studies have tried to make different quality management practices into a meaningful set of critical success factors helping users theorize the quality management models more easily. According to Saraph et al., (1989) critical success factors are management practices, actions, or pre-conditions vital for successful quality management. Quality management practices have been researched widely; for example, Saraph et al. (1989), Flynn et al. (1994), Powell (1995), Ahire et al. (1996), etc., and numerous studies adopted these researchers' studies. Each one of these research studies determined dimensions of QM being applied by organizations to achieve competitive advantage.

Talib et al. (2013a) developed a reliable and valid instrument necessary for the successful implementation of TQM program in Indian ICT based organizations from 84 Indian companies and it was concluded that Indian ICT companies perceives total management commitment, continuous improvement and innovation, quality culture, training and education, customer focus, teamwork, quality systems, product and service

design, process management, communication regarded as the ten most important quality management practices. While the five quality management practices such as strategic planning, information and analysis, benchmarking, employee involvement, employee encouragement are being perceived to be the important (moderate) quality management practices and the remaining two practices include Human resource management and supplier management to be the least important practices in Indian ICT industry. Talib et al. (2013b) investigated the relationship between TQM practices and quality performances in Indian service industries using a self-administered instrument that was distributed to 600 Indian service organizations, which include healthcare, banking, ICT and hospitality industry. Findings of this study revealed that TQM practices were found to be partially correlated with the quality performance. It was also found that quality culture was perceived as the dominant TQM practice in quality performance. Other practices such as quality systems, training and education, teamwork, and benchmarking showed a positive relationship with quality performance. Keng- Boon Ooi (2014) in his study provided a deeper insight into more detailed view of TQM practices to examine whether the six dimensions of MBNQA model i.e. HR management, customer focus, leadership, information analysis, process management and strategic planning have the same effect on both manufacturing and service sectors in relation to knowledge management behaviours, whereas it has been found that there is no difference, hence indicating the importance of MBNQA-TQM practices to both industries. Yeh and Lai (2015) evaluated the effectiveness of implementing quality management practices in medical industry and identified key QM practices in order of importance which include: top management involvement, departmental communication and coordination, teamwork,

hospital participation, education & training, consultant professionalism, continuous internal auditing, computerized process and incentive compensation.

Consequently, the critical success factors have emerged most frequency in quality management studies; these components of quality management practices are: Leadership, Strategic Planning, Customer Focus, process management, employee relation, and supplier management which were explained before. Other critical success factors of quality management practices are not presented in this research study, because of its very few framework regularities; therefore, that investigators omitted it. However, this research study examines the role of top management commitment in implementation of quality management (as critical success factors of quality management practices), as main factors would affect quality management.

2.4.6.1.The Importance of Leadership in Quality Management

Leadership is a significant factor in successful implementation of QM performances as a driver of QM. Leadership generates goals, values, and frameworks to fulfill customer needs and expectations and enhance association's execution (Ahire et al, 1996). This factor is not just reported by quality leaders (Deming, 1982; Juran, 1988): additionally, it is said in experimental studies (Table 2.3) that leadership can enhance execution by influencing other QM practices (Anderson et al, 1995; Wilson and Collier, 2000).

The role of leadership in QM shapes the foundation of any development technique. Leaders provide solidarity of purpose, and build up the direction of the association. For

this reason, the accountability of leaders comprises of improving and keeping up the internal environment. In this environment, workers have the capacity to totally end up in achieving the association's aims and objectives. Along these lines, great leadership is vital to enhance quality over the association, as the leading force that sets goals and helps workers to implement these goals. As stressed by several models, leadership is fundamental in implementation of quality management. For instance, the European Quality Award model the Malcolm Baldrige National Quality Award the respect leadership, as the principal empowering factor in QM.

Implementing QM needs a collaboration headed by the association's leadership group. Every individual included in change management having her or his obligations, and it is essential for the whole association comprehending the role of leadership in QM to make delegating obligation more efficient.

Traditionally, it has been argued Easton & Jarrell, (1998); Douglas & Judge, (2001); and Hendricks & Singhal, (1997) that the role of overseeing quality is fundamental in today's environment, being proved by the popularity of the QM development. However, the role of leadership in overseeing quality is moderately unaddressed in the leadership literature. Regardless of the acknowledgement of the building legitimacy of the QM idea by organizational behavior academics (Hackman &Wageman, 1995), and its significance in the field of management approach (e.g. Dean & Bowen, 1994; Spencer, 1994), research study on QM as appropriate to role of leaders, has not got much consideration (Waldman, 1993) in any of the methods to leadership examination (House 1997). Hence,

the potential for coordinating the leadership literature with the QM literature is incredible and prone to be valuable for both practice and theory. This research is an endeavor at such incorporation of QM and leadership literatures.

The developing literatures on QM focus on the significance of QM to organizational execution and have constantly focused on the absence of leadership support as a reason for the failure of numerous QM activities. Several researchers have analyzed the implementation of QM and its effect on organizational performance (Douglas & Judge, 2001; Jayaram et al., 1999), with both arrangements of academics recognizing strong positive connections between the implementation of QM and performance (Hendricks& Singhal, 1997).

Numerous investigators in the QM literatures have recognized the significance of the role of leadership in managing quality (e.g. Anderson et al., 1994; Dean& Bowen, 1994; Repenning & Sterman, 2002). According to Hackman & Wageman's (1995) there is a strong agreement among quality development authors that leadership plays a significant role in managing quality (Crosby, 1979; Deming, 1986; Feigenbaum, 1983; Juran, 1994). The purpose of this literature review is to expand the QM and leadership literatures and progress a theory of leadership, concentrating clearly on the role of hospital leadership in implementing QM. The following chapter provides leadership theories. As mentioned above, it required reviewing the leadership theories comprehensively.

2.4.7. The Problems & Barriers with the Implementation of Quality Management

Quality management is lately regarded as a way of managing organization, improving product/service quality and the general efficiency of manufacture or companies operations. Even though there is evidence supporting the efficacy of quality management initiatives in organizations, a great number of researches show that between 60% and 80% of quality management initiatives are unsuccessful, or fail to have important practical effects. Furthermore, research has shown that numerous organizations encounter difficulties in implementing quality management. Researchers within quality management alliance have suggested the following reasons for this failure (Dale et al. 2007):

- Lack of focus on the Process
- Fear of Change/ resistance to change
- Misperception that QM is a set of tools rather than a way of thinking
- Inconsistent management commitment from department to department
- Lack of rewards and recognition
- Organisations are more concerned about short-term business returns rather than long-term sustainability of business performance.
- Lack of Top Management Commitment.
- No supporting infrastructure for cultural change.
- Lack of synergy between quality improvement programmes and overall business strategy.
- Poor management leadership

- Inappropriate organizational structure

To summarize, management systems are required in all parts of actions whether small and large industries, service, private, or public sectors. Implementation of quality management in manufacturing industries sets direction and meets customers' expectations, increases market share, decreases expenditure, and progresses process control. In the following sections quality management in manufacturing, service of developing and developed countries, and finally quality management in private and public sectors are discussed.

2.5. Quality Management Systems in Different Sectors

Quality Management is an integrative management Philosophy aiming at incessantly improving the performance of services products and processes to attain and improve the customer's expectations. According to the literature review, there are much dissimilarity in service industries and manufacturing (Nilsson et al. 2003; Sun 2001; Solis et al. 1998; Singh et al. 2006; Powell 1995). This section reviews the notion of quality management in both manufacturing and service organizations identifying the important differences (if any) in quality management practices. The simple aim of QM is *"Do the right things, right the first time, every time"*. QM is unlimitedly adaptable and variable. Though QM was initially applied to manufacturing operations, and for a number of years was merely utilized in that part, quality management is now becoming realized as a common management tool, just as applicable in service and public sector organizations (Garg et al,

2006). There are a number of evolutionary aspects with dissimilar sectors developing their own types from the common antecedents.

Whereas the literatures focusing on quality management have improved unconnectedly for services and products, the founders of total quality draw this management viewpoint as universally oriented. In order to understand quality management greatly, it is indispensable to review quality management system in manufacturing industries sector and service industries separately and plus evaluate similarities and differences between these industries. The following sections review quality management system in manufacturing industries and also in service industries.

2.5.1.Quality Management in Manufacturing

Quality management practices in manufacturing sector offer definitions to organization-wide quality practices (Saraph, Benson, & Schroeder, 1989). The literature has emphasized the key dimensions of quality management in terms of quality information, supplier and customer involvement, product design, and procedure management. Sterman, Repenning, and Kofman (1997) utilized a framework based on processes, human resources, product development, financial and cost accounting, and competitive environment and analyzed the implementation of QM in a manufacturing industry. A number of authors have considered empirical analysis of quality award models, establishing their importance in quality management (Hendricks & Singhal, 1997; Wilson & Collier, 2000; Flynn & Saladin, 2001). Furthermore, models demonstrating the effect of quality on operating, financial and market performance are

available in the literature (Flynn et al., 1995; Samson & Terziovski, 1999; Ahire & Dreyfus, 2000; Das, Handfield, Calantone, & Ghosh, 2000; Hendricks & Singhal, 2001; Kaynak, 2003). A model for quality management driving factory performance was developed by De Groote, Loch, van der Heyden, van Wassenhove, and Yucesan (1996).

Previous research findings developed an instrument for measuring quality management implementation in manufacturing-based business units in India (Joseph, Rajendran, and Kamalanabhan, 1999). They recognized 150 measures of quality through a detailed analysis of literature. On conducting a pre-test, 111 measures were utilized to progress a questionnaire. These elements were empirically examined and further analysis revealed ten dimensions of QM with 106 operating quality system measures in ten quality management scopes.

The next section discusses quality management in the service sector as essential as the field study of thesis in hospital.

2.5.2. Quality Management in Service

Although services are a great part of the economy, the ideas of service quality are not extended as those of manufacturing quality (Ghobadian, Speller, & Jones, 1994). This may be due to the fact that manufacturing and service literatures presently treat quality management in a different way (Harvey, 1998; Sousa & Voss, 2002). According to Harvey (1998), most service quality research utilizes the gap model to evaluate service quality (Harvey, 1998). The gap model was first suggested by Parasuraman, Zeithaml,

and Berry (1985), to study five gaps between service performance and customer expectations; however, it does not directly consider many of the components of total quality.

Regarding the success of implementation of quality management in manufacturing, scholars have started to examine the potential to move and employ quality management practices and principles to service organizations. This makes a problem since both the American and Japanese quality management gurus extended their ideas regarding quality management from their knowledge in working with manufacturing companies. Even though these individuals have proposed the applicability of quality management to the service industry, scholars have noted several items, which hinder the realization of quality management to service section. Academics have also distinguished some elements, which could impede the implementation of quality management among service organizations due to the essential differences in the character of their business. Particularly, there are numerous key features differentiating manufacturing firms from service firms, which may influence the movement of the quality management tools, techniques and principles to service environments. The most prominent features are the heterogeneity and intangibility of the outcomes of services, which in contrast to those in the manufacturing industry are more standardized and measurable in their qualifications (Sureshchandar et al., 2001). For instance, the notion of SERVQUAL assessing quality of services extended by Zeithaml et al. (1990) is dominated by non-physical fundamentals including accessibility, courtesy, and responsiveness. Being more idiosyncratic than those in manufacturing region, and the way customers would judge and perceive the quality of

service, it is complicated for service companies to describe customers' requirements and expectations obviously. The additional difficulty in employing QM techniques and tools in the service industry is affected by the dissimilar operation systems, while the utilization and delivery processes occur simultaneously. This develops difficulties for service suppliers in monitoring the quality of the service outcomes before delivering them to clients, as is generally done with manufacturing produces.

In contrast, the literature also proposed that quality management has developed further than simply capturing systems and tools (including SPC, ISO 9000, so on), and its spotlight has changed to conceptual points instead of practical ones. Consequently, while primarily proposed in a prescriptive and highly practitioner-oriented shape, QM is admitted as a management philosophy that exemplifies a set of standard center main principles, which are unlimited by industry-unique concerns (Dean and Bowen, 1994; and Grant et al., 1994). The recent disputes related to QM have supported the contingency model of the quality management core philosophies application into dissimilar environments (Sitkin et al., 1994). This argument sets a basic field to support the applicability of QM in service organizations and thus offers chances for their profiting from implementing QM which forces the utilization of its techniques and tools, not well matched to the service sectors. Furthermore, the improvement of the *"soft"* features of QM focusing on behaviors and attitudes, including involvement, empowerment, customer focus, leadership, and cultural features of QM, has encouraged its application in the service industry. Lastly, corresponding to these positive arguments, Woon (2000) proposes that several service areas have a similar method of processes or

operations to manufacturing, called *"manufacturing-oriented services"* (likewise identified as *mass services*), making them able to adopt QM practices and principles. Silvestre (1998, p. 321) proposes *"the core principles of QM are highly relevant to services, although the concepts are developing and sprouting in different ways in the service literature"*.

The standpoints of the authors of QM (Deming, Juran, and Ishikawa) are prominent in the manufacturing literature, however, not in services. Yet the theoretical methods of total quality support its utilization for both services and products (Anderson, Rungtusanatham, & Schroeder, 1994b; Waldman, 1994). Indeed, Deming (1986) dedicated an entire chapter of his book, Out of Crisis, to service industries. Furthermore, the Malcolm Baldrige National Quality Awards (MBNQA) program, founded by the U.S. Congress in 1987, included seven groups being by any organization, whether in services or manufacturing sector (Bergman and Klefsjo, 2007).

2.5.3. Differences between Manufacturing and Services

Manufacturing is regarded as being accompanied by those organizations where there is a very low level of direct contact with the customer, as 'primary sector'. Manufacturing needs a physical change in the form and utility of resources. Manufacturing firms are defined as *"those producing tangible products with a noteworthy element of their operations function involving manufacturing activities, such as underdone materials being transformed to a product"* (Dale et al. 1997 pp.5) Services are defined as *"a procedure transiting inputs such as strategy, technology, skills etc. in to an yield i.e.*

service". Service companies also are defined as those, which produce intangibles with a service operations focus (Johnson and Nilsson, 2003). Numerous investigators have recognized four features of services that distinguish manufacturing organisations from service organizations. These are: inseparability, intangibility, perishability, and heterogeneity. According to Zeithaml et al., (1985) the differences between manufacturing and service industries are as follows:

- Inseparability

This contains simultaneous consumption and production, recognizing most services. The incapability to store services is a critical aspect of most service actions. Since the customer must be present throughout the production of numerous services, indivisibility 'compels the purchaser into friendly contact with the production procedure' (Carmen, 2000). This simultaneous consumption and production removes many opportunities for quality control intrusion.

- Intangibility

Since services are performances, concepts or ideas rather than objects, they cannot be felt, heard, tasted, smelled or seen in the same way in which products can be identified (Ograjensek, 2002). Once purchasing a produce, the buyer is typically capable to feel, see, and oftentimes test its earlier shopping performance. However, with services, the customer must frequently rely upon the character of the service organization. This significantly affects the anticipation aspects of quality dimension in services.

- Perishability

This submits the perception that a service cannot be inventoried or saved (Bessom, 1975). Vacant hotel rooms, empty airline seats, and unfilled appointment times for a doctor are all examples of opportunity losses. This perishability offers a problem of synchronizing provision and need, making customers to wait or not be served altogether. The implications for customer satisfaction are quite understandable.

- Heterogeneity

Given that different human resources at the same capacity or different facilities can provide the same services, the quality and essence of the service are different from supplier to supplier, from customer to customer, and from day to day. Trying to offer a reliable service or assessing the changeability of different presentation types can be difficult. Unlike manufacturing, in which the product is screened before delivery, services must trust in a series of procedures assuring the reliability of output (Zeithaml, 1991).

A number of research studies have evaluated the dissimilarity in implementation of QM between service and manufacturing and service industries. The research by Beamount et al. (1997) among 85 service organizations and 261 manufacturing organizations indicates that service organizations utilize less QM tools, particularly statistical process control. Woon (2000) also conducted a similar study among Singaporean organizations. By a sample of 240 companies in the Singapore Quality Award program, the study recognized that the service companies commonly presenting a lower level of quality management implementation than the industrial organizations predominantly consider the elements of process management, information and analysis

and quality performance. However, there was no significant difference concerning the elements of leadership, human resources, and customer focus. This is consistent with the above argument that the *"soft"* features of quality management are more applied in service organizations comparing the "hard" aspects. Early research findings by Huq and Martin (2000) examine the dissimilarity of quality management implementation between 18 service and 18 manufacturing companies according to 19 quality management dimensions. They determined that the service companies employ quality management practices selectively rather than the manufacturing companies, which use a full range of quality management practices. However, form the literature review, no significant differences between manufacturing and service companies regarded management commitment, empowerment and communications, mission statement, and customer focus, which reflects the *"soft"* aspects of quality management. Recently, numerous health care organizations have implemented the practices and principles of quality management in order to solve most of the challenges they are currently facing (Chesanow, 1997; Counte, Glandon, Oleske, & Hill, 1995; Kim & Johnson, 1994). The next section discusses the quality and quality management in healthcare.

The management systems are required in all areas of performance, from small and large businesses, service or public and private sectors and manufacturing to implementation of quality management setting up direction and meeting up customers' expectations, reducing wastage, increasing market share, improving process control. The following sections exclusively discuss the significance of quality management in healthcare and environment in hospital sector.

2.6. The Importance of Quality Management in Healthcare Systems

Health services contain an extensive diversity of quality aspects, all being essential. In case of medical services, the vendors are hospitals, nurses, doctors and clinics, etc., since they deliver health services for sale. The customer is the patient who purchases these health services at the stipulated prices. It may also contain quality of performance being directly connected and closely related to healthcare for example food, safety, security, housing, manner of workers, and other elements related to hospitals. Consequently, it includes the time it takes to the fix an appointment, service time, delay time, timing with reference to medical cure and operation.

- Quality of hospital care
- Quality of administration and management
- Quality of doctors

Additionally, in the quality chain reaction, Deming (1989) highlights the point that progress is followed by fewer mistakes, decrease in cost because there is less rework, better employment of machine time less delays, etc. This rather enhances competitiveness and productivity. Utilizing the similar chain reaction in the healthcare industry results not only in cost reduction in the administrative purpose, but also in inhibiting expensive or lethal mistakes producing loss of life and law suits (Zabada et al., 2001). According to Hamilton's report (1982), 90% of medicines prescribed result in waste of money,

unnecessary surgery, spoiling billions of dollars, risk of serious side effects and making thousands of death each year.

2.7. Concept of Quality and Quality management in Healthcare Service

Scholars define quality in healthcare in various ways. Some consider quality as superiority of excellence, whereas others strive it as lack of patient care and service deficits. Consistent with Crosby, quality is 'conformance to requirements'. The American Society Quality (ASQ) and American National Standards Institute (ANSI) define quality as "*the totality of features and characteristics of a care or service that bears on its ability to satisfy given needs"*. The visions of quality as the satisfaction of customer requirements is regularly named fitness for utilize.

This research study is related to reflecting on three definitions of 'Quality in Health'. The first being offered by the IoM, holds that Quality in Health is the 'degree to which health services for individuals and populations amplify the probability of preferred health outcomes and are in agreement with existing specialized knowledge' (IoM, 2001). According to the World Health Organization (WHO), the quality of health is offered as 'an incorporated set of planned activities based on the definition of clear goals and performance evaluation, covering all levels of care through incessant improvement of quality of care' (WHO, 2000). The third definition: the Department of Health in the UK defines it as 'doing the right things at the first time to the right people at the right time, in the right place at the lowest cost' (1997).

Deming (1986, p5) holds, *"quality ought be intended at the requirements of the customer, present and future"*. Whereas Crosby (1996, p24) regards quality as *"conformance to requirements and ...conforming to specification"*. There is agreement among researchers that a blend of these two descriptions is suitable in the framework of health care services, because it significantly meets the customer's requirements and desires, despite the fact that such service ought comply with realized standards and needs assuring safety and avoiding harming patients. The quality system program in hospitals focuses on the assessment of the quality of the service, and training as opposed to globally accepted professional standards (Sohail, 2003).

Peculiarly, these definitions undoubtedly regard the need for any healthcare system to assure excellent consequences of care by proper processes and structures and the support to satisfy all interested parties. This is reasonable for the health sector particularly in hospitals.

Service in health care institutes is perishable and intangible. Health care organizations cannot make their services earlier than the time required. Indeed, in many cases they must be offered within minutes of appeal and most significantly, health care organizations cope with intangible (Huq, 1996), person priorities, thus quality systems implementation in these institutes is mostly a challenging duty. According to the definition of the ISO, the quality system is the organizational construction, processes, resources and accountabilities for implementing QM (ISO 8402, 1994).

Tannock and KrasachoI (2002) view that in developed nations, for example the USA, Japan and UK quality management has been a vital subject for more than two decades in all business areas, mostly manufacturing. On the other hand, in many developing countries, quality management is a new and challenging management method. Recently, the application of QM practices has gained attention in hospitals in numerous countries, involving America and Europe. Nevertheless, it is essential to implement progressive quality management if healthcare suppliers desire to undertake their complications efficiently (Ching, 2003).

According to Dranove et al. (1999), almost all hospitals in the US are included in quality improvement programs. They add that 98% of roughly 2000 hospitals in 1997 were utilizing continuous quality improvement. Wagner et al. (2003) discovered that 71% of all healthcare institutes were training their workers in QM in the Netherlands. In Europe, there was an imperative to increase attention in implementing quality development plans in the 20th century (Ovretveit, 2001).

Regardless of its industrial starting point, QM established a footing in health care for a numeral of reasons. The increase in the expense of health care through all the years, brought about by rapid technological advances in the medical field has been phenomenal. From the evidence, hospitals have changed into extremely complex institutes, and physicians are exceedingly specialized. New progresses in medicine have led to finding new drugs, which are not cheap, as official document rights and the commercialization of pharmaceutical goods is a too familiar landmark of the healthcare landscape. Health

professionals shall be trained and retrained to keep pace with fast developments happening in the medical world. On top of all this, medical proceeding has played an important role in contributing to the mushrooming costs of health care.

Growing healthcare costs present the question whether higher expenses improve quality of care, or better quality of care can truly be attained at a lower cost. Milakovich (1991) stated that quality of care and cost control can exist at the same time, and are not necessarily mismatched. Ovretveit (2000) indicated how waste in health care could be measured in the course of quality price. Harkey and Vraciu (1992) offered experiential evidence on the connection between the quality of health care and financial performance. However, the idea that health care service quality is equal to the supply of more services is intensely implanted in the health care industry. Indeed, there is extreme debate about the perceived balance between cost and the quality of services (Ovretveit, 2000).

However there is no agreement regarding how to improve the health care industry more effectively and efficiently; consequently, more and more leaders of health care organizations are willing to adopt the tools and principles of QM in order to fulfill those objectives. QM is attractive to health care managers because of its spotlight on improving and maintaining the quality of care, while at the same time comprising costs. Chan and Ho (1997) cited a study carried out in 1993 on 3,300 hospitals in the USA, indicating that about 70 per cent of the hospitals had implemented various QM systems. In addition, Wagar and Merode (2003) cited a study of 1,300 Canadian health care institutes, indicating that more than half of the respondents had implemented QM in their

organizations. However, casualties have been high. Huq and Martin (2000) reported a 60-67 per cent implementation failure rate, and attributed it mainly to fruitless implementation systems being compared with basic flaws in the philosophies of quality management. However, QM set up its foothold within the health care industry.

Whilst health care organizations have embraced QM, concerns are raised about the appropriateness of QM in the health care environment; particularly, Arndt and Bigelow's (1995) dispute that assumptions characteristic in QM, that are hierarchical, control the technical and central part of logical decision-making, which may not be interpreted well in a hospital environment. Wagner et al. (2003) claimed that the results in health care are difficult to define, measure and control compared with other service or manufacturing operations. Health difficulties incline to be more compound, and need a great deal of customized solutions, which is improved by the specialized autonomy endowed through society on health specialists. This feature of health care disaccords with the conformist QM method relying upon a high level of standardization and control of adaptability. Notwithstanding the uncertainties, QM sustained to infuse the health care segment on a worldwide level, in a move by health care institutes to examine the solution to their patients.

The idea of whole TQM being first implemented in the manufacturing part in 1980s was followed by the service segment and other sectors. Recently, many health care organizations have implemented the practices and principles of TQM in order to solve most of the difficulties that they presently face (Prajogo & shoal, 2006; Powell, 1995;

Tari, Molina, & Castejon, 2007; and Sila, 2007). The reasons at the back the broad acceptability of QM in health care organizations are numerous; however, before underlining these reasons it is vital to understand what TQM is in context of health care environment. According to Arasli, (2002, p. 347) it is defined as:

> *"The satisfaction of patients, doctors, nurses, and suppliers (i.e., social shareholders) and other interested groups, achieved by implementing effective planning, programs, policies and strategies (i.e., hard issues), and human and all other assets (i.e., soft issues) efficiently and continually within a hospital context"*.

Hashmi (2004) defines TQM as *"a management philosophy that seeks to integrate all organizational functions to focus on meeting customer needs and organizational objectives"*, whereas Powell (1995) states, it can be normally clarified as the procedure of making quality as the concern of everyone in the institute. These two definitions were propped up by Ennis and Harrington (1999), who highlighted the significance of multidisciplinary cooperation as a basic precondition of total quality management, in which each member of the group has a role to play in carrying on patient care leading to a cross-functional method where no department or individual is superior to another. Even though there are innumerable definitions for total quality management, what actually matters for the leaders is applying the basic notions in a way that is suitable to its specific industry situations.

Due to lots of reasons such as the main cash flow difficulties of hospitals and cultural concerns, the application of QM to the healthcare industry was restricted while it was introduced in the late 1980s. However, as Mclean, (2006) indicated that the most important barrier to the agreement of QM by the healthcare sector was a practical concern related to the shortage of agreed principles and standards to justify noncompliance and deviation.

The worth of quality management to clinical decision-making improved considerably when the United States Institute of Medicine (IOM) launched the patient safety movement with its book of "To Err Is Human" (Mclean, 2006). The IOM announced that 98,000 Americans die every year because of avoidable medical faults. In reaction, the senator and physician Bill Frist declared that *"the many errors that result in prolonged hospitalization more misery and greater expenditure can totally be prevented"* (Mclean, 2006). He was asking for the extensive application of QM to the health care setting, since QM was established to decrease medical errors, thereby progressing suppliers' results (Mclean, 2006).

The IOM, nevertheless, states that health care nowadays regularly struggles with ineffectuality in delivering its possible benefits (Institute of Medicine, 2001).

Having sent a report to IOM since 5 years ago, it has been shown that 85 percent of all malpractice occasions were not because of bad doctors. Rather the malpractice happened because the hospital, where the doctor worked, had a defective or absent QMS (Mclean,

2006). If hospitals desire to solve their difficulties more practically and effectively, it is vital to implement QM (Institute of Medicine, 2001).

Additionally, the TQM emphasizes continuous improvement, organizational culture and structure, process management, cooperation, systemization, customer (patient) satisfaction, and finally supportive leadership and commitment from management. Several studies have also focused that successful implementation of TQM results in considerably superior results in health care institutions (Yang, 2003; Mclean, 2006). Some of these outcomes are as follows:

- Reduced operating cost of health care institutions
- Employees' satisfaction
- Patient safety
- Upgraded quality of services
- Improved health care quality and performance
- Patient satisfaction

Consequently, health care organizations have begun to implement QM scrupulously. Even some of the hospitals links and institutes have required all their health care organizations to adopt QM as early as feasible. Some of the studies demonstrate the positive characteristics of QM movement for hospitals such as competitive advantage, financial performance, quality development, and employee commitment in various hospitals (Alexander, Weiner, & Griffith, 2006; Chesteen, Heigheim, Randall, & Wardell, 2005; and Douglas & Judge 2001).

A research study carried out by Lee et al. (2003) concluded that besides a wide method for quality development, for the success of quality management implementation in hospitals, they need to control, and increase an incorporated performance measurement system.

Horng and Huarng (2002) in their research study based on examination of 76 hospitals in Taiwan, tested a multilevel model addressing the matter of QM adoption. The outcomes of the study suggested that the character of the network relationship and prospector strategy as the two constructs out of five recognized constructs, are significantly and positively related to the degree of quality management adoption. Further study indicates that prospector strategy is connected to QM adoption for profit earning hospitals, whereas network relationship is relevant to quality management adoption for public hospitals.

According to Komashie, Mousavi, and Gore (2007), although the theory of quality has a long history, however, the regulation of quality and its control in health care industry are not as highly advanced as manufacturing organizations. They expressed several reasons, for instance the type of events and manufacture concerned, and dissimilarities between the two industries regarding concerns for quality.

Chow-Chua and Goh (2000) concluded that innovative approaches and continuous development for example TQM have produced time-saving and cost-effective ways to

make work processes more efficient. Furthermore, they concluded that large hospitals and public hospitals are more prone to implement TQM approach, whereas medium sized hospitals had a tendency to use continuous improvement as a means of quality improvement.

Similarly, other research studies based on TQM in the health care environment are those of Ovretveit (2000), Satia and Dohlie (1999), Brennan (1998), and Aggarwal and Zairi (1997).

In summary, TQM and QMSs, including JCI and other types of QMS are utilized as frameworks to incorporate all organizational activities and functions, meeting organizational objectives, ensuring customer satisfaction and promoting continuous development.

The Commission International (JCI) Accreditation standards for hospitals can be considered as a quality management system followed by healthcare institutes to develop patients' safety and quality via focusing on stability of care. As Dale (1999) notes the aim of quality system is to create an outline to support stability in the institute. According to JCI (2003), the following are several significant characteristics of its standards as a quality context that can be utilized by healthcare institutes:

- It needs top management involvement and commitment of all healthcare providers in the implementation procedure.

- External and Internal audits are utilized to compare each institute's presentation with best practice levels of performance.
- Constant self-assessment is encouraged to guarantee the stability of implementation of the standards.
- Internal assesses of the medical certification and annals of healthcare providers ought to be conducted to recognize parts for development.

As McFadden et al. (2006) point out the JCI standards establish a QM context for hospitals with great stress on the patient safety implementation approaches. The patient safety implementation denotes the procedure of carrying out specific methods such as education and training, system redesigning, and open discussion of errors, with the purpose of removing patient damage and diminishing medical faults. According to McFadden et al. (2006) hospital quality management has been progressively tied to interference and the avoidance of hospital mistakes. It is essential that hospitals improve efficient explanations to decrease medical mistakes in order to reinforce quality of patient care. Consequently, patient safety is one of the factors of JCI standards and an instrument to support quality of care in hospitals (McFadden et al. 2006).

2.7.1. Quality Management in Hospitals

QM has become a significant subject in hospitals since the 1980s (Kunst et al., 2000). The rising attention to quality is because of the influence of customers, other stakeholders, government influence, and hospital management schemes.

Recently, healthcare systems have turned into the basics of happiness in all levels of hospitals in our societies. Ultimately, there is increasing importance and dependence on quality management in healthcare systems. This increasing significance is reflected in the rising proportion of national and international resources for both public and private areas assigned to hospital management systems. Hospitals and other healthcare institutes all over the world have been increasingly implementing QM to develop efficiency, decrease costs, and offer high quality patient care. Unlike the commonly held belief, the QM movements were not the start of interests about quality in healthcare. The origins of quality assurance plans in healthcare dissemination dates back to Florence Nightingales' work during the Crimean War (1854-1856), while the introduction of sanitation and disease control initiatives and nutrition in war hospitals helped to decrease death rate from 43% to 10%. QM can be a significant part of hospitals' competitive strategy. Consequently, QM, being on the basis of developing customer satisfaction, provides the view of great market share and productivity.

QM can be a significant segment of hospitals' competitive strategy in quality of healthcare system. Hospitals in competitive markets are more likely to try to distinguish themselves from their competitors on the basis of superior service quality. Accordingly, QM, which puts emphasis on development in customer satisfaction indicator, provides the grater outlook of mixing internal quality measures with value analysis and compliance with conditions (Kunst et al., 2000). Suitable quality services not only include direct medical services like treatment, medicines, diagnoses and surgery, but also indirect operations like purchasing and management whose costs are mirrored in what the

consumer pays (Kunst et al., 2000). It may additionally include quality of performance that is directly related to healthcare safety, attitude of nursing security, and role of doctors regarding ‘time’ including timing, service time, delay time and appointments for surgery and medical treatment.

2.8. Quality Management in the Public and Private Sector

The value and validity of any comparison between the roles of private and public sector managers depends on the affiliation between the two segments. From the literature review, paradigm numerals have been suggested to explain this relationship. The paradigms have been suggested to explain the claimed dissimilarities between private and public management (Osborne, 2006). The pattern of ‘Public Administration’ emphasizes on the specific political and economic characteristics of the public segment. Based on this viewpoint, there are essential dissimilarities between the private and public segments; therefore, comparisons between the two sectors are of less value.

Over a decade ago, the ‘public Administration’ model was challenged by a different paradigm, named ‘New Public Management’ which concentrates on the creation capacity of public associations. This paradigm reduces the contrasts between private and public segments, considering that purposes and strategies (cost, decrease results) are comparable in both divisions. Therefore, the high level of comparability advocated by this paradigm again renders fruitless similarities between the two segments. On the other hand, advocates of ‘New Public Management’ and of the broad changes it includes, have a

tendency to legitimize their demands for change via personifying public sector similar to an anachronism based outmoded administration procedures.

Osborne (2006) recognized a third rising model, the paradigm of 'New Public Governance', underlining the pluralist and plural nature of public associations and the relationship between policy of implementation and political initiative. Based on Osborne's ideas, New Public Governance concentrates on service effectiveness, outcomes, and the governance of processes' (2006: 384), that is to say it focuses on the worldwide outcomes of a public activity on its environment (results), instead of the quick results of a public service production function (outcomes). From this viewpoint, the differences between private and public parts are no longer so different, as contrasts have a tendency to be troubles of degree as opposed to absolutes. According to Louart (1997) the distinctions inside sectors are sometimes greater than the contrasts. According to the New Public Governance paradigm, contrasts between the private and public segments turn out to be considerably more relevant.

The imperative to enhance quality while decreasing costs has constrained private and public segment hospitals to re-assess their quality programs (Ernst, 1994). The re-assessment has turned the consideration of numerous health care associations to industrial quality practices, specifically, to QM (Arndt & Bigelow 1995).

According to White (1994), a comparison of private and public organizations (not restricted to health service agencies), takes various important contrasts between the

segments into account. Firstly, the essential purpose of the private segment is to return a profit, while the government segment has various and sometimes conflicting roles, endeavoring to balance financial effectiveness with social obligation. Additionally, government organizations have a tendency to have their clients defined for them, while private segment clients are constrained to those who can pay for the service on proposal. Third, because of the bureaucratic nature of government offices, change occurs significantly more slowly than in the private section. Ultimately, public divisions have various complex social obligations, involving empowering groups to address recognized issues. The private segment is far less responsible in this part.

2.9. Quality Management and National Context

There is a developing awareness of the requirements to extend theoretical examination from industrialized nations to recently developing nations. Hofstede (1994) asserts that national culture influences the idea of management; therefore, that management differs country to country. Cultures may contrast in that the desires of the leader for the followers and the desires of the group for the leader are extremely different across countries (Ayman, 2004).

2.9.1. Quality Management in Developed and Developing Countries

In the previous twenty-five years, worldwide competition has been on the increase. Organizations situated in developed nations are discovering that it is hard to compete with units working in areas with moderately low wages. Additional to the problem is the

developing volatility of the business environment due to the presence of various multinational actors, fast changes in innovation, and high rivalry.

To survive in this extremely competitive market, organizations in both developing and developed countries are adopting QM programs. The interest for quality is no longer the privilege of the developed nations. With adopting of global quality guidelines, for example, ISO 9000, quality is rising as a one of the most significant elements for all organizations contending in the worldwide marketplace. Numerous organizations around the world, specifically those in Japan, Western Europe and the USA have implemented QM as a method for boosting consumer satisfaction, increasing better product quality, and acquiring higher efficiency through the reduction of nonproductive activities and the systematic evacuation of waste. Numerous organizations in developing nations need to go with the same pattern; however, they do not know how to implement of QM, nor do they know which factors are essential (Yoo and Park, 2007).

Though various individuals have widely analyzed QM in developed nations, for example, UK, Japan, U.S and other European countries, just recently some investigators have started to study quality practices in developing nations. Comparative analyses benchmarking quality practices among nations are likewise inadequate. Among comparative analyses benchmarking quality practices in two or more developed nations (e.g., Ernst & Young, 1992), not many (e.g., Knotts & Tomlin, 1994) have benchmarked quality practices in developing nations with those in developed nations. From the literature, in general, the quality development was slacked in developing nations;

likewise, minimal experimental work has been done to investigate QM in developing nations. There are various general debates of distinctive methodologies (World Health Organization, 2006; Reerink and Sauerborn, 1996; and Al-Assaf, 2001), involving discussions about utilizing "Western" quality approaches in middle and low-salary countries (Tillinghast, 1998; and WHO/ISQua, 2000a). National quality projects in low-salary nations have additionally been described (Whittaker et al., 1998, WHO/ISQua, 2000b, c; Azwar, 2000, Massoud, 2001; Bouchet et al., 2002; and Øvretveit, 2004a). Regarding specific methods for enhancing hospital quality, the literature reports diverse approaches including:

- Quality dimension and follow up (Peters and Becker, 1991; Thomason and Edwards, 1991; Vera, 1993; Thomason, 1993; Haddad et al., 1998; and WHO/ISQua, 2000d);
- Skill development and training (Woodward, 2000; and Brown et al., 1998);
- Standard setting and review (Novaes, 1996; Lian and Marnoch, 1999);
- Quality-team based methods (Miller Franco et al., 1997; Brown et al., 1998; and Bouchet et al., 2002);
- Organization audit or accreditation (Whittaker et al., 1998; Arce, 1999; Rooney and van Ostenberg, 2000; Bukonda, 2000; and Huang et al., 2000); and
- Clinical audit (Noorani et al., 1992; and Maher, 1996).

These distinctions in QM practices between developing nations and developed nations, however, appear to be opening business sectors to multinational contenders, and

the extent of universal quality principles, for example, ISO 9000 to developing nations. Nowadays, developing nations are starting to perceive significant developments in quality, investigate quality practices in developing nations, and benchmark their practices against those in developed nations.

Enhancing the quality of health care has turn into a concern for managers, professional's workers, and governments in developed nations, where numerous individuals don't have admittance to services. Patients with money, however, are paying extra for their care in private and public services; however, they regularly don't experience any developments in service quality or health. According to World Health Organization (2004), patients exceedingly expect more from health care services and compare their experiences regarding those nations with superior quality. Quality health care is one element of a nation's health, which has been connected directly to national wealth (World Health Organization, 2004a).

In general, there are insufficient findings that have compared QM in developing nations with developed nations (Tzavaras Catsambas et al., 2002) and even less in Middle East countries such as Iran (Habit et al., 1997; Massoud, 2001; and Øvretveit, 2004a).

Developing nations have additionally been headed to consider quality issues. Iran is a sample of one such developing nation that has *"jumped on the bandwagon"*. In order to achieve international effectiveness and meet customer' needs, many Iranian institutions have sustained their QM practices (Karimi et al., 2012).

Recently, some research has been done about QM in developing nations; there is inadequate research about the relationship of quality practices and their impacts on quality presentation. For instance, Cebeci and Beskese (2002) merely analyzed how quality circle meetings influence exports inside a restricted arrangement of Turkish industry. Su et al.'s (2008), investigation of Chinese organizations demonstrated that QM practices contributed to business performance through quality presentation and development. Based on Mellahi and Eyuboglu's idea (2001) in Turkish banking services, the critical factors for successful implementation of QM were an educated management team, assistance during and after quality management implementation, and training and management commitment. The analysis of implementation of quality management in Fiji by Djerdjour and Patel (2000) demonstrated that the fundamental factors for successful implementation of QM in Fiji organizations were threat of competition, marketing, and better management. Challenges of QM implementation in Fiji incorporate the misunderstandings that QM was a quick fix, the resistance of shop-floor employees and needed too much unnecessary paperwork.

Several comparative research studies of quality management practice discovered that there are several different features in nations and no nation contrasts in other aspects. For instance, Najeh and Kara-Zaitri (2007) analyzed 32 quality aspects in five nations: Palestine, Kuwait, Malaysia, Libya, and Saudi Arabia and discovered that 12 out of 32 quality elements were critical successful factors considered in all the five nations. These 12 quality elements were clear mission statement, organizing for quality, quality cost,

effective communication, employees and management, customer needs, continuous improvement, multi skill training, quality planning, staff development, top management involvement, and top management commitment.

Laosirihongthong and Dangayach (2005) claimed that quality management stands out amongst the most favored activities for development in Indian and Thai car manufacturing organizations. However, other research studies have not discovered contrasts by nation in QM practice levels. For instance, Jabnoun and Sedrani (2005) neglected to discover contrasts in QM practices of the United Arab Emirate as opposed with developed nations. Hyland et al. (2000) analyzed the diverse quality practices of Australian organizations at distinctive phases of implementing continuous improvement programs (CI) and discovered no nation contrasts utilizing Wacker and Sheu's (1994) transformative advancement model.

In spite of the proposals that there is no distinction in quality management practices among the nations and regardless of TQA's award, the Thai culture may influence business practices. Kumbanaruk (1987) considered distinctions among the Thai and Japanese workers and uncovered that the Thai tend to acknowledge things, as they seem to be, whereas the Japanese have a tendency to solve issues that they distinguish. Thai culture is described by the idea of "Kreng Chai" characterized as considering "the other individual's feelings into account" (Kumbanaruk, 1987, p. 95). According to Kumbanaruk (1987), this feature did not support the quality circles idea that people share their thoughts to solve issues. Subsequently these individuals like to evade direct

showdown so as to keep up harmonious connections, while a person in a quality control circle opposes somebody in the quality circle he may not share his experiences in an issue. In an examination of the elements affecting industrialization in nine Asian nations from 1996 to 2000, Chan and Quazi (2002) uncovered that in one third of the nations regarded quality development and that just ISO sort quality management frameworks were generally accepted.

2.9.2. Quality Management Practices in Iran

According to WHO (2000), good health, responsiveness to the anticipations of its people, and financial contribution to the country are the purposes of health care services of a country. An over-perspective of the picture throughout the world demonstrates that regardless of having various great health care facilities, there is an adequately extensive gap between the demand and delivery. Iran reports each capita consumption of US$ 215 on health. There are nine doctors available for each 10, 000 individuals in Iran.

With expanding rivalry, progresses in health sciences and increasing patient anticipations, the healthcare frameworks have got to be complex associations. Iranian health care services require acquiring an ideal harmony between the patient satisfaction and assets. Quality management (QM) has an extraordinary potential to address quality issues in an extensive variety of industries and enhance the Iranian organizational performance.

Iran is an important country in the Middle East. With a population of approximately 70 million, it is the most crowded country in the area and the 16th most densely populated nation in the world. Iran is the second biggest OPEC oil producer and has the world's second largest reservoirs of gas. This country, with an ancient civilization, has a globally imperative cultural domination in both the region and the world (World Bank, 2001). Quality management (QM) has been presented in Iran from 1981 onwards. To empower organizations in implementing QM, great endeavors were made by National Productivity Organization and the Iranian government. Iranian hospitals began implementing QM programs from 1999 (Lameei, 2005; Mosaddegh, 2005). According to Lameei and Mosaddegh (2005), the long-term goal was to offer the essential circumstances for implementing QM. Consequently, a National Committee for Quality Improvement (NCQI) was built up. NCQI was assumed to offer training and advice regarding quality improvement initiatives. It is essential to point out that despite the fact that National committee on quality assurance (NCQI) has arranged a structure for implementation and preparation of all essential materials and training courses, a *"roadmap/blueprint"* for implementation is not improved, nor was a *"compulsory /prescriptive"* method for doing the assignment imposed. National committee on quality assurance (NCQI) was the starting point, but the Iranian hospitals are not free to adopt or reject QM. Despite some endeavors to implement and develop the QM, however, it appears it is still in its infancy as in several cases just a couple of research studies have be done about the application and implementation of QM. The current literature has demonstrated that no wide-scale research study has been systematically carried out dealing with QM practices and their impacts on general performance in Iranian hospitals.

Consequently, in order to fill this gap, an examination into the impacts of implementation of quality management in Iranian, public and private hospitals are really required. Such a research study can investigate the role of hospital leadership in quality management implementation on overall performance in private and public hospitals. This study additionally supports distinguishing the issued areas and feasible solutions to the implementation of quality management.

According to Salaheldin (2009), there are numerous empirical research studies examining QM practices and performance relations in large organizations; however, the medium and small size organizations still require somewhat more consideration of academics (Salaheldin, 2009). Whereas the literature regarding quality measurements in the health care service is loaded with studies from the developed world, investigators from developing nations have been investigating the relevance of the related frameworks and models in their particular context. In Iranian context it appears there is no established system for measuring quality endeavors and performances of health care services industry (Duggirala et al., 2008). According to Zakuan et al. (2010), regardless of the number of quantity of research and number of publications on QM, there is little experimental work done in developing nations. In spite of the fact that there are confirmations of recent studies in Iran relating to TQM and performance in health care (Duggirala et al., 2008), none of them deals with the issue in totality. Furthermore, the presence of numerous multinational organizations in developing nations, for example, Iran ought to develop awareness of quality practices, suggesting that most QM practices

are found in Iranian industry. However, literature is not adequate about the QM system in Iran and it could say it is unaddressed in Iranian literature.

The present state of research in the area of health care quality alongside the deficiency and cost of health care services in Iran (GHO, 2009) appear to justify the current research study named *"the implementation of Quality Management Systems and the role of hospital leadership in in Iranian hospitals"*.

Consequently, Iran has been selected as the case study of this thesis as Iran can be fairly unique and interesting to discover the kind of quality management, how it is implemented, and investigates the role of hospital leadership in QM implementation, and additionally, how quality can be managed depending on the condition. From the literature review the critical factor effecting implementation of quality management is 'top management commitment' which is mentioned by many academics. Strong commitment from the top management is fundamental in QM and prompting to higher quality performance. A numbers of scholars agree with this idea (Saraph et al., 1989; Flynn et al., 1994; 1995; Ahire et al., 1996; Juran, 1988; and Anderson et al., 1995). As this research study investigates the role of leadership in implementation of quality management, the next part of literature review (II) reviews leadership theories.

2.10. Chapter Summary

This part reviewed the literature regarding quality, quality management, implementation of quality management, quality management in manufacturing and

service industry, quality management in public and private hospitals, developing and developed countries especially Iran as a case study.

From the literature review, the notion of quality is as elusive as it is pervasive. The difficulty of definition consequently makes it difficult to attain worldwide agreement on the notion. Consequently, this research study needs to find out definition of quality used in the case study organizations. In addition, the literature review proposes that quality improvement is affected by some factors, such as top management support, process management strategic planning, supplier management employees' relations, and customer focus. Based on reviewing the literature, top management support has been highlighted by most researchers in contributing to quality management. Strong commitment from the top management is fundamental to quality management and strong top management could also influence quality management practices because leaders play the function of motivators who guide subordinates. Consequently, quality improvement is directly related to strong top management. However, much of the existing quality management research has not utilized any constructs from leadership theory to assess the significance of leadership in quality management. In other word, the existing leadership approach has not used in the concept of quality management. Based on the literature, the role of hospital leadership in implementing quality management is not addressed. Therefore, this research study will identify the role of hospital leadership in implementation of quality management. Consequently, the comprehending provided by the literature review assisted the investigator to frame the questions for the interview protocol. Next chapter reviews leadership theories as a critical factor effecting the implementation of quality

management.

The review will cover the following key areas:

- A discussion of the philosophies and theories of Leadership, definition of Leadership and Leadership vs. Management.

- A discussion of the traditional theories of leadership and identify the need for more research into conceptualizations and theories of acknowledging the embedded nature of leadership in the organizational context.

- A discussion of role of leadership and leadership in private and public sector and also highlighting the similarities and differences between these area, particularly emphasizing the leadership in healthcare environment sector as this was chosen as a case organization for this research study.

Research Strategy Utilized in the Literature Review

The following points are considered in the literature review:

- In conducting the search, the researcher examined merely literature published in English and utilized the search terms *'leadership, 'leadership theories, 'hospital leadership, 'distribution leadership ' and 'role of leadership'*. The EBSCO and Emerald databases were mostly utilized to perform this search since the greatest relevant journals and papers could be discovered there. Several of the papers studied in these databases covered literature specific to hospital leadership and the quality management implementation in hospitals. More than one thousand

documents were found under the beyond search terms. The researcher ultimately chose more than three hundred journals to be utilized in this research study or to spread her knowledge of the subject.

- Some additional literature was reviewed and recognized following the empirical step of research and throughout the discussion of the empirical findings of the four case studies.

- To assess the strength of the literature and to distinguish between academic research papers and other points of literature such as magazine articles, the researcher measured the subsequent elements affecting the choice of literature: Is the article peer-reviewed? Is the paper (article) appropriate to the topic under examination? Is it established on empirical research with a suitable approach? These facts directed the researcher in recognizing the role of leadership in implementation of quality management. Moreover, in some conditions, the researcher found references to appropriate PhD theses related to the results of articles and case studies in particular frameworks. The researcher has been constant to make sure that when reviewing any part of this research study, the priority be given to peer-reviewed research papers.

Leadership is both an art and a science (Goetsch and Davis, 2006)

3.0. Introduction

Leadership is an essential social phenomenon, being considered as the key to powerful adaptation and survival of effective worldwide organization (Ford and Harding, 2007; Regine and Lewin, 2000). The requirement to cultivate leadership capabilities amongst structural members, to get competitive advantage and develop organizational presentation, is reflected in the expansion of leadership advancement programs over the public and private areas in the United Kingdom (Day, 2000; Van Wart, 2003). Nonetheless, Leadership as an idea is baffling, with a multitude of definitions and dimensions (Barker, 1997; Burns, 1978). What leadership is and how leadership success can be assessed is savagely disputed.

Exacerbating this issue is a dependence on traditional, leader-centric theories, forming a significant part of the current research in this domain. According to Avery (2004) and Dess & Picken, (2000), these theories have been insufficient in providing a satisfactory understanding of the leadership procedure, especially in more complex settings, for example, hospitals, where leadership may not happen in hierarchical fashion. First, in this literature review chapter, I propose an assessment of these traditional theories of leadership and recognize the requirement for more research into conceptualizations and theories recognizing the implanted nature of leadership in the social setting. I will support the need to regard leadership as a social procedure, as opposed to singular event forced

on others (Day, Gronn, &Salas, 2006). Finally, I consider the leadership theory in quality management system, as the research focus is the role of hospital leadership in implementation of quality management.

3.1. Definition of Leadership

Leadership can be described in a wide range of ways, to some extent as it has reviewed from the viewpoint of diverse fields of endeavor. Leadership has been described as being utilized by the military, business, industry, education, and numerous different fields. Regarding the purpose of this research study, leadership is characterized as being related particularly to total quality:

> *"Leadership is the ability to inspire people to make a total, willing, and voluntary commitment to accomplishing or exceeding organizational goals".*

Barker, (1997), Bass, (1990a), Burns, (1978), and YukI, (1989) point out that the challenge of defining the leadership notion is a remarkably complex one, ranging from a concentration on individual 'heroic leaders', to a dynamic, contextual group procedure of 'leadership'. Although research study in the field has generally concentrated on the individual attributes, traits, behaviors, or actions of individual 'leader' (Bass, 1985; Judge, Pccolo, and Kosalka, 2009), more recent efforts to theorize leadership have criticized the individualistic attitude as imperfect and distorted (Ahn, Adamson & Dornbusch, 2004; Barker, 2001). It is believed that leadership resides within definite individuals (Denis, Langley, & Roulean, 2005; Kellerman, 2004; UhI-Bien, Marion & McKelvey, 2007). Performing within official hierarchical organizations no longer reflects

the complexity of modern structural cultures, and neglects to consider the contextual effects on its performance.

Kelly, (2008) points out that Leadership cannot be appropriately defined regarding the characteristics and activities of individuals. Instead of being a fixed and detectable event, leadership is all more viably seen as a verbose, dynamic and contextual process, which can be utilized comprehend complex organizational phenomenon perfectly (Bryman, 1999; Osborn, Hunt, & Jauch, 2002).

According to these theories, definitions of leadership will modify according to temporal and contextual changes, with people developing their own assumptions and definitions of leadership based on individual experience and perceptions (Avery, 2004; Kort, 2008; Osborn et al., 2002). This permits investigation of organizational phenomenon in both fluid and contextual manner, as opposed to being compelled by a singular, practical definition of 'leadership' (Bresnen, 1995, Washbush, 2005). However, there was no comprehensive definition regarding the definition of hospital leadership. Accordingly, this thesis tries to present a comprehensive and all-inclusive definition for hospital leadership.

It is believed that a further obstacle in conceptualizing leadership is the capacity to evaluate the effect and results of processes on organizations (Barker, 2001; Osborn et al., 2002; Svensson and Wood, 2005). Endeavors at assessing leadership effectiveness depend on traditional and individualistic assumptions; analyzing organizational result

measures, for example profits and market shares, and assuming the presence of a direct relationship between effective leadership and business result (Svensson and Wood, 2005). In spite of this, there is little confirmation to exhibit a quantitative relationship between individual behaviors or traits and organizational performance (Howell, Bowen, Dorfman, Kerr, and Podsakoff, 1990; Kaplan and Norton, 2005). This does not imply that leadership has no immediate impact, but rather that the results may be played out through social mechanisms compared to organizational output.

Researchers have attempted to determine the social impact of the leadership process and highlighted the social and contextual influences on perceptions of leadership effectiveness, and associated outcomes (Avolio, Reichard, Hannah, Walumbwa, & Chan, 2009; Giessner, Van Knippenberg, 2003). These subjective opinions highlight the vague nature of the concept, making it difficult for individuals to vocalize clearly and consistently how they view it (Alvesson & Sveningsson, 2003a, b). The rhetorical dimension of leadership further complicates the research, as its subjective nature means researchers' perceptions and respondent bias will influence the standards and constraints of discourse (Alvesson & Sveningsson, 2003a, b; Connelly et al., 2000; Hooijberg & Choi, 2000; YukI, 1989).

3.2. Leadership vs. Management

As Northhouse (2010) points out, leadership and management are similar in many ways. Both leadership and management involve influence, working with people, and

efficient objective achievement. In summary, several management roles are actions in line with the leadership definition.

However, leadership is different from management. While the study of leadership started with Aristotle, the study of management dates back to the 20th century with the beginning of industrialization. Management was formed as a method to decrease disorder in societies, and to create them more efficiently. To Fayol (1916) the most important roles of management were *planning, organizing, staffing,* and *controlling*. Even now, these roles are delegate of field of management. However, Kotter (1990) believed that the roles of management and leadership are rather different (table 3.1). The main function of leadership is to create movement and change, whereas the primary function of management is to offer consistency and order to organizations. Leadership is about attempting adaptive and productive change; management is about seeking stability and order.

Table 3.1. Functions of Leadership and Management

Management Produces Order and Consistency	***Leadership*** **Produces change and movement**
Planning and Budgeting ▪ Establish Agendas ▪ Set Timetables ▪ Allocate Resources	Establishing Direction ▪ Create a Vision ▪ Clarify big Picture ▪ Set Strategies
Organizing and Staffing ▪ Provide Structure ▪ Make Job Placements ▪ Establish Rules and Procedures	Aligning people ▪ Communication Goals ▪ Seek Commitment ▪ Build Teams and Coalitions
Controlling and Problem Solving ▪ Develop Incentives ▪ Generate Creative solutions ▪ Take Corrective Action	Motivating and Inspiring ▪ Inspire and Energize ▪ Empower Subordinates ▪ Satisfy Unmet Needs

(Kotter 1990, p.103)

As indicated in table 3.1, the primarily activities of leadership are different from the functions of management. However, Kotter (1990) asserted that leadership and management are dissimilar in scope, but both are crucial if an organization is to success. For instance, if an organizaton encompasses strong leadership but not management, the result would be misdirected and meaningless. On the other hand, if an organization encompasses strong management but not leadership, the result would be bureacratic. In order to be successful and effective, oranizations are required to promote skilled leadership and competent management.

Besides Kotter, many authors believe that management and leadership are different constructs. Nanus and Bennis (1985) for example, continued that there is a important distinction between these two functions. To lead means to influence group memebers and produce visions for change, whereas to manage implies to complete tasks and master routines. They also made the difference especially obvious in their commonly quoted sentence, *"leaders are people who do the right thing and managers are people who make things right"*(p.221).

3.3. Theories of Leadership

YukI (2006) notes that leadership theories are dynamic, and many of them have been criticized as contradictory, simplistic, and vague because, theoretically, they are not well defined. Accordingly, these concepts are empirically and conceptually poor, potentially inhibiting the development of leadership study (Yuki 1989; Gronn, 2002). Bryman (1999) categorized leadership into three parts: individualistic approaches, contingent leadership, and new leadership theories. This section reviews hypotheses and problems associated with leadership theories, research and suggest the require concentrating on new types of leadership approaches: leadership in context.

3.3.1 Individualistic Approaches and Contingent Leadership

YukI (1989) identified that individualistic theories of leadership emphasize on the concept of 'heroic' individuals who compel actions on other. Trait theory demands the

hypothesis that individual be born with innate traits, making it possible to become effective leaders, even as behavioral approaches concentrate on how people are able to act to develop into successful leaders (YukI 1989; Northouse, 2007). Some scholars believed that trait theories view the leader separate from organizational and social influences (Howell et al., 1990; Hooijberg & Choi, 2000; YukI 2006). They also proved trait theories are frequently discredited because of shortage of practical facts representing an apparent connection between individual leader characteristic and individual results. The individualistic theories can propose some approaches into the trait and personal features of individuals who are supposed successful (Bass, 1990a; Hooijberg et al., 2000; Judge et al., 2009). However, as trait theories rely on simplistic concepts of leadership as fixed personality results, and are not concerned about contextual aspects, they have come under criticism.

However, some scholars address this gap by suggesting different circumstances which need adaptive leadership behavior and theory in a dynamic temporal fashion, rather relying on prescriptive forms (Ahn et al., 2004 Northouse 2010). Leader would be able to maximize their organization efficiency if the leadership styles match the contexts (Kent, 2005 & Grint, 2005).

It is believed that despite progresses in individualistic approaches, contingency theories continue imperfectly. From viewpoints of Bass (1990a) and Grint (2005), the negative point of this approach is that this theory still emphasizes on the idea of leadership as inherent in individuals, and does not include the leader within the broader

system or his role in organizational context. From evidence, there is no clarification of why some leaders would be more efficient than others in diverse situations, and there is also no apparent experimental evidence as to his effect on organizational act (Howell et al., 1990).

3.3.2 New Leadership Theories

New theories have been tried to resolve the errors of the traditional theories through recognizing and increasing requirements for an appropriate theory to leadership. Fred Fiedler (1967) was the first researcher to suggest shifting the focus of leadership studies from the behaviors or traits to contingencies of the condition in order to clearly comprehend the effectiveness of a certain style of leadership. From that time, the context of leadership has significantly drawn to much attention. The findings identified by Hooijberg (2001) indicated that even though some 'new' theories of leadership have turned their consideration back to the transformational or visionary, charismatic leaders, their cognitive capability, behavioral complexity, or social intelligence.

Furthermore, Burns (1987) takes a broader approach to leadership theory, classifying it in two approaches: *transactional* and *transformational*.

Transactional leadership style is associated with managerial processes, demanding a structure of punishments and rewards and making sure of accomplishing the purposes (Burns, 1978 and Bass, 1990). Transactional leadership relies on punishing and rewarding behavior, depending on the situation, in order to attain the desired results

(Seltzer & bass 1990; Bass 1990a). However, according to Burns, (1978); and Bass, (1990b) this style of leadership is not seen as effective in the long term, because of a desire to attain person interests instead of a shared vision, however, dose not generate interest or commitment among subordinates. Furthermore, Bass (1990b) notes that the approach is frequently associated with management because of its dependence on conformity to objectives instead of challenging organizational limitations. The leader possesses official authority letting them exert rewards or punishment on the subordinates.

Unlike transactional leadership frequently regarded as ineffective, transformational leadership is commonly viewed as one of the most successful leadership styles (Bass, 1990, Avolio & Bass, 1995). Transformational leadership emphasizes on leaders persuading and motivating the subordinates to achieve the desire goals. It is expected from transformational leadership to behave in a perfect fashion, in which the subordinates are motivated to work toward a shared vision, and persuade transformational manners through the organization (YukI, 1990; Bommer, Rubin, & Baldwin, 2004; Jung, Yammarino, & Lee, 2009).

Management and leadership are conceptualized as different processes by the new leadership approaches, with managers using transactional methods and leader employing transformational characters (Avolio, &Popper, 2001). The distinction between transformational and transactional leaders has revealed that transformational leaders raises the level of organizational novelty and prompts higher levels of employee satisfaction than transactional managers (Avolio & Bass 1995; Berson, Shamir, Avolio,

&Popper, 2001; Jung, Chow, &Wu, 2003). The results of transformational leaders have been demonstrated across organizations and multiple cultures, in which the assertion of great leadership relies on transformational manners (Dorfman & Howell 1997; Ruiz-Quintanilla, Den Hartog, Hanges, House & Dorfman, 1999). According to Jung et al. (2003), the key to effective transformational leadership is charismatic behaviors, which are required to persuade increased follower performance across different contexts (Kent et al., 2001).

Howell & Shamir (2005) claim transformational leadership is frequently perceived as identical with charismatic behaviors, and engages leaders' performing as a responsibility model for the values they desire other to adopt. Burns 1978 and YukI, (2006) in their work shoed that in charismatic behavior, leaders emphasize their manners or traits as 'special' features which promote them beyond their group, and distinguishes them as somehow fundamentally different. Some scholars Bass (1990a) believe charismatic leaders have been associated with extreme religious factions, frequently due to the unquestioning nature of subordinates.

However, when explored in less extreme circumstances, charismatic leadership is consistently linked with measures of effective leadership and increased organizational performance (Alge, Nagarajan, Sonnenfeld, & Srinivasan, 2006). Charismatic behaviors are seen as essential components of transformational leadership as individuals should be promoted beyond the group and viewed as responsible for attaining influence (Seltzar & Bass 1990; Bass, 1990b; Howell & Shamir, 2005).

Antes, Caughron & Friedrich (2008), and Strange & Mumford (2008) has suggested that even though the significance of the charismatic aspect of transformational behavior reveals viewing successful leadership as 'transformational' is excessively simplistic and narrow. Bedell-Avers et al. (2008) and Strange & Mumford (2002) argue that transformational leadership can be demonstrated in three different approaches: pragmatic, charismatic and ideological. These styles are distinct in terms of the way they try to influence their subordinates depending on the circumstance and in type of vision, and consequently demand the leader to adopt their transformational style in diverse conditions to attain organizational effectiveness (Bedell-Avers, Hunter & Mumford, 2008; Bedell-Avers, Hunter, Angie, Eubanks, Mumford, 2009). According to Bedell-Avers et al., (2009); Strange & Mumford (2002), pragmatic leaders focus on the functional requires of the organizational structure whereas, charismatic leaders focus on historical values. Overall, the distinction between three categories of transformational leadership recognizes the contextual impact on leadership and the way perception of successful leadership manners will changed consequently, thus this develop the capacity of leaders to operate conditionally and be successful.

3.3.3 Problem with New Leadership Theory

Tejeda, Scandura, & Pillai, (2001); Schrisheim, Wu, & Scandura, (2009) claim, despite reliance on an new leadership theories in current research, there are some problems with theoretical framework, frequently linking to a sustained lack of contextual consideration. The transformational style provides an opportunity for leaders adopt their

behavior according to dissimilar condition, but in practice this characteristic is often neglected (Avolio, Bass, & Jung, 1999; Tejeda, Scandura, & Pillai, 2001; Schrisheim, Wu, & Scandura, 2009). Transformational approaches often rely significantly on individualistic hypothesis.

Furthermore transformational style criticized for lack of distinction between transformational behaviors and charismatic (YukI, 1999). YukI (1999) noted that the potential for mutual influence between leader and subordinates is also ignored in this approach, and instead the emphasis is merely on the capacity of the leader to influence others. Transformational effectiveness is consequently declined to leader-centric comprehensive of individual traits, rather than being concerned with organizational procedures (Shamir & Howell, 2005).

The new leadership approaches focus on individualistic notions of leadership, which attribute organizational success and effectiveness to performance of group members, and formal leaders situated in the organizational hierarchy. However, these theories have not revealed in the reality of modern institutes, which should be relied on informal and formal leaders functioning within systems rather than hierarchies (Mehra, Smith, Dixon, & Robertson, 2006; and YukI, 1999, 2008). Drath et al. (2008) point out that the possible contributions of transformational styles are undermined through theories regarding leaders, subordinates and their collective targets. Consequently, the existing research has not provided a broad comprehension of leadership as dynamic and complex, social development.

3.3.4 Leadership in Context: Post Transformational Approach

Until recently, most reviews of leadership theories were not considered in social process; in addition, they lacked a common framework. Instead, the theory viewpoint suggests trying to examine it in isolation as a fixed, individual result. The perceptions of leadership has earned new interest by the current stress given by some scholars; if leadership is a discursive mechanism, a theory employed to investigate organizational occurrence should rely on the context in which the process happens (see Fairhurts, 2009; Heracleous &Hendry, 2000). Lord, Brown, & Harvay (2001a) and Johns (2006) showed that perceptions of leadership behaviors would be influenced significantly through the context in which the process occurs. Accordingly, some researchers conceptualize that perceptions of the leadership context requires to be expanded to all organizational levels, instead of dyadic level, to view the emergent, non-linear processes which would be influenced by leadership processes (Morgeson & Hofmann, 1999; Hunt & Dodge, 2000; Uhl-Bien & Marion, 2009).

Denis, Lanley, & Roulean, (2007) take a broad approach to leadership theories, in which contextual influences are mainly significant in modern organizations which could be described as ‘Pluralistic’, which in turn indicate an institute with knowledge-intensive work force, multiple goals, and distributed leadership. The theory has generated much interest among scholars for including multiple networks of teams and overlapping hierarchies. These organizations, therefore, meet more vertical, hierarchical, and spatial complexity. Based on their analysis of a series of recent studies on modern organizations

Heifetz, Grashow, Linsky, (2009), and Pearce et al. (2007) found that organizational vision and change are driven by multiple formal and informal leaders at diverse hierarchical levels. The most widely cited researches on leadership in context are Basadur (2004) and Heifetz, Grashow, Linsky, (2009) on distributed leadership, which could encourage adaptive change, organizational innovation, and therefore, increase organizational performance (Basadur, 2004; Heifetz, Grashow, Linsky, 2009).

3.3.5 Distributed Leadership

Based on new perspective on leadership which described as theories of distributed, or shared; leadership reveal the growing significance of team procedures in organizations since scholars have been tried to move away from traditional hierarchies towards flatter organizational structure (Day et al., 2006; Avolioet al., 2009). Distributed theories have provided several individuals could play the role of leaders in an organization in informal emergent fashion instead of being employed in formal roles of leadership (Day et al., 2004; Carson et al., 2007). From this perspective, Day et al. (2004), and Friedrich, Vessey, Schuelke, Ruark & Mumford (2009) identified that informal theory permits the positions of leader and his followers to become blurred; with individuals taking on informal leadership position in a contextual procedure responsive to organization requires.

The most widely cited research on the emergence of leader is Marion & UhI-Bien (2001) pointing out that the emergent leaders throughout the organization build a chain of informal systems, leading to a creative and innovation surroundings. According to these

writers, the reality of leaders dispersed throughout the team or organization, persuading leadership behaviors among whole members of organizational, positive organizational change and innovation, and rising commitments (Marion & UhI-Bien, 2001; Gronn, 2002; Pearce; Manz, & Sims Jr, 2008). Researchers have also found that distributed leadership could enhance group performance, member satisfaction, and outcomes in a further influential shared vision rather than one forced top-down by formal leaders (see Pearce et al., 2007; and Friedrich et al., 2009).

Although it is good to be bright, the research by Ensley, Hmieleski, & Pearce (2006) indicates that empirical links among organizational performance and distributed leadership found it to be more helpful and beneficial compared with vertical leadership and traditional frameworks (Pearce & Sims Jr, 2002). Further research undertaking a broader approach to distributed leadership suggests efficient combination of formal vertical and informal leadership would provide more positive organizational and individual outcome. However, it is believed that implementation of this model in practice would be more complex. Further research by Bolden, Petrov, & Gosling, (2009), Carson et al., (2007), Curries, Lockett, & Suhomlinova (2009a) point out that the interaction between bottom-up and top-down informal, emergent influences could lead to considerable tensions. There is also research showing that distributed leadership can be very restricted if formal leaders do not authorize the emergence of informal leaders throughout the organizational structure.

However, the Distributed theory has earned new interest through the current emphasis given by many researches, particularly in the UK public sector, where the educational and health sectors consist of gradually more complex systems, be related multiple professional groups and hierarchies (Harries, 2007; Martin, Currie & Finn, 2009). In spite of the advantages of a distributed theory to leadership, Bolden et al. (2009) went so far as to argue that the approach is poorly defined and the concept is underdeveloped. He also argues that instead of being an obvious model, shared or distributed leadership is employed interchangeably as analytical frameworks or rhetorical strategies (Bolden et al., 2009). It is believed that a number of components of distributed approach need additional consideration.

In a qualitative synthesis of earlier research by Schneider & Somers, (2006), it is asserted that if power and leadership are distributed at compound levels throughout an organization, it may lead to conflicting ideas of emergent leaders, resulting in chaotic and potentially destructive environment. The findings of Mehra et al. (2006), Denis et al. (2007), and YukI (2008) suggested that in order to tackle this problem, formal networks and strong informal are needed to direct leader actions and make certain informal and formal leaders work towards strategic visions and overarching organizational goal. Yet there is lack of research on how this model works in practice; also, the influences of possible conflict between formal and distributed leaders have been considered, mainly with regards to the way in which formal leaders are able to give up control and power inside the organizational structure (Regine & Lewin, 2000; Balkundi & Kilduff, 2005; Harris, 2007). From Harris (2007), and Pearce & Sims Jr (2002) point of view, this model

requires additional empirical research; however, the research focuses on the development of distributed leadership in implementation of quality management.

3.4. Role of Leader

However, most of the leadership qualities pointed out earlier may not to be valid in reality, and leaders may be unaware of how to promote their development. Literature has paid less attention to the role of leadership and instead has focused on how leaders are completing that role. Thus, it is essential to respond to three questions: fist, what is the role of leadership?, second, what is the role of nonexistent ideal leadership in practice? Finally, what is the role of all the characters that the literature into leadership takes into account in developing leaders? However, this research will focus on the role of leadership in quality management.

Kouzes and Posner (2003) point out leadership is all about making choices. A choice is a binary act that is split into two options, the undesired and the desired ones, according to a superior value and principle (Rawls, 1999). A choice, therefore, implies that as options are similarly valid, one will decide according to a higher value. According to Mostovicz (2008) the way persons are selected is affects their worldview and the way which they discover their *"ideal self"* (Hinkle, 1965).

However, from the literature review most leadership capabilities appear not to be real, aspiring leaders may persist unconsciously as to how to promote their progress. Literature has paid less attention to the role of leadership and instead has focused on how leaders are accomplishing that role. Hence, it is important to identify the role of leadership in

implementing a process such as quality management system, which this research study has focused on.

3.5. Leadership in the Public and Private Sector

There is a simple inquiry: Are there any important differences in features of public segment leaders and those of their private segment counterparts and the leadership patterns? Definitely, it is secure to state that all associations, notwithstanding their activity, have dissimilar cultures and features that will end up in forming diverse managers. Moreover, according to Anderson (2010) if single study one association and competes all of its leaders, there would be dissimilarities. He also claims that if there are dissimilarities inside a specific organization, how one can discover the dissimilarities between industries and segments for that matter. There have been a few scholarly studies to answer these inquiries. Those who study public administration comment that there are very few studies conducted focusing solely on leadership in the public sector. Anderson (2010), however, studied numerous research studies carried out since the 1970's. Numerous findings were based on past examination. In spite of the fact that several features were researched, most of the findings led to similar conclusions. Anderson (2010) asserts that three elements that have been considered in an effort to define if outstanding differences or similarities are the decision-making styles, the leadership styles, and motivation profiles of several leaders inside different private and public organizations.

A considerable amount of literature has been published on leadership theories. These studies found that there are significant dissimilarities among leaders in diverse divisions. That prompts to inquire the subsequent question, why? Why dissimilarities while private and public leaders confront the same "challenges of achieving organizational goals with or through other people" (Anderson 2010, p.140). Likewise, staffs in the private and public areas perform the same indistinguishable tasks (Anderson 2010, p.131).

According to Cook (1998), "*what makes public administration and public management 'public', and thus, distinctive, is the politics at the heart of the enterprise"* (Anderson 2010, p.138). In additional, Anderson (2010) expresses *"public management scholarship has suggested that public organizations are fundamentally different from private organizations as a result of the functions they provide to society"* (p. 138). Scholars put forward that since there are incredible differences between private and public organizations, there will be contrasts to a shifting degree between their leaders. The next section is a rundown of conclusions that have been drawn by those directing the research studies:

- There is an absence of market incentives in the public sector (Robertson 1991)
- There is a lack of market incentives in public part (Robertson 1991)
- Public organizations must acknowledge objectives determined by other organizations (Hooijberg 2001, 405)
- Operating constructions in public organizations determined by other organizations (Bower 1977,140)

- Private objectives are less equivocal in light of the fact that they can be assessed in financial results (Hooijberg 2001, p. 405).
- Public leaders must achieve objectives in less time (Bower 1977, 140).
- Public administrators must seek multiple objectives at the same time (Hooijberg 2001, 405)
- The public area having more "specialized and invariant job designs" (Hooijberg 2001,405)
- There are harsher reporting connections in public area (Hooijberg 2001, 405)
- There is a more elevated amount of responsibility in public organizations (Hooijberg 2001, 405)
- There is more administration turnover in public segment (Hooijberg 2001, 405)
- Public staffs have more prominent job security (Baldwin 1987) (Hooijberg 2001, 405).
- Public sector concentrates more on superiority in its reward system (Hooijberg 2001, 405)
- Public organizations must agree with civil service policies (Hooijberg 2001, 405).

3.5.1.The Differences of Public vs. Private Leaders

Discretionary Power

A large and growing body of literature has investigated that public sector is characteristically more organized than private organizations. These highly structured

organizational features, ordinarily put in place by statute, substitute the requirement for a strong leader. These feeble leaders are seen as having little discretion of their own (Kerr 1978). According to Osborn and Hunt (1975), in traditional leadership theory, the subordinates respond mainly to their leader's discretionary impact.

Behavioral Differences

The study by Anderson (2010) determines whether there are behavioral contrasts among private and public sector leaders and whether organizational dissimilarities lead to contrasts in behavior. Academics tried to focus on this by employing a generic model in both private and public organizations and measure the results (Pacek, 2010). Likewise, academics inferred that those working in the public division recognize a feeble relationship between a goal-oriented leadership role and adequacy and therefore, support the transitional monitor and facilitator role (Anderson 2010). Similarly, Hooijberg (2001) proposes that inside the public sector, older leaders are more effective. This is most likely due to the position of the civil service framework. As Hooijberg (2001) notes, *"relationship behaviors and effectiveness might be significantly different between these two sectors because of different environments in terms of market forces and exposure to legislatures, and civil service rules"* (p.404). These distinctions influence the *"discretion afforded to leaders in these sectors and that affects how they lead"* (Hooijberg 2001, 404).

Leadership Style

In a study conducted by Anderson (2010), three behavioral measurements were investigated. Leadership style "*describes the behavior of the leader by task, relationship*

and change orientation" (Anderson 2010, p.132) and is characterized as "an aggregation of traits, skills and behaviors" (van Wart 2003, p.222). Table (3.6) shows the consequences of the research study.

Decision-Making Style

'Decision-making' and problem solving are imperative components of management (Anderson 2010, 132). Anderson utilizes Carl Jung's Typology to classify the diverse decision-making styles. Jung (1921) identified that all human behavior is guided by four functions when endeavoring to solve a problem:

Functions utilized in recognizing problems

- **Intuition**- probabilities in the future
- **Sensing**- perception through senses

Functions utilized in solving problems

- **Feeling-** assesses and judges
- **Thinking**- understanding and meaning

Motivation Profile

Academics found that the *"need profile"* (signifies the relative strengths of the three requirements) for public leaders was higher for affiliation and achievement that need the profile of private leaders. They also found that private managers were more power-

motivated (Anderson 2010). (Behavioral similarities and dissimilarities between private and public leaders Chart). Everyone has a requirement for:

Affiliation- the desire to determine and continue friendly associations

Achievement- the desire to perform better than others or solve problems

Power- the desire to control others and impact conduct

Table 3.2: Behavioral Similarities and Differences between Private and Public Leaders

	Public Leaders	**Private Leaders**
Leadership Styles	*Change-Oriented Style* Offers philosophies regarding different methods of doing things; pushes for development; initiates new projects; experiments with new ways of doing things; gives thoughts and strategies for the future (Arvonen 1999, p.245)	*Relationship Style* Shows respect for his/her coworkers as individuals, is thoughtful, is friendly, trusts his/her subordinates, permits his/her subordinates to choose (Arvonen 1999, p.245).
Decision-Making Style	Intuition Seeks to misuse the probabilities; arranged towards the future; attempts to find new potentials and discover new solutions; utilizes imagination; gets carried away with new thoughts and probabilities and ignores practical realities (Jung 1971).	

Motivation	*Achievement Motivation* Goals to outperform someone else, meet or exceed some self-imposed standard of excellence, do something unique, be included over long term in performing something well (McClelland1972, p.34)	*Power Motivation* Desires to have effect; making an impact on others; make intense activity; exert strong negative or positive emotions in others; have concern for own reputation (McClelland 1972, p.34)

Behavioral Similarities and Differences between Private and Public Leaders (Anderson 2010, p.137).

As noted by Anderson (2010), strong leadership would surely be found in any successful organization regardless of sector, public or private. It is believed than not all organizations are the same pretty much as not all individuals are the same. It has been discussed whether leaders are made or born, or possibly a mix of both. The private and public divisions deliver service and product, generally, for the same customer and the same sector. Workers of these distinctive organizations conduct the same tasks and leaders cope with the similar issues (Anderson 2010). Numerous academics complain there is dearth of research about the topic, as Anderson noted (2010), there is so little research on leadership in public division because of budget deficit. Private organizations are freer to hire outside specialists to assess their institutions, and their leaders make suggestions. Public organizations are funded by government, and it appears to be less likely to do the same as private. That being the case, public division leaders need to expand their leadership skills and are compelled to consult general models. This research

study puts emphasis on comparing and contrasting the private and public organization specifically in hospital environment.

3.6. Cross-Cultural Leadership

The effect that culture has on leadership can be appreciated in something as straightforward as how leaders are perceived in diverse cultures. In societies with an exceptionally stratified distribution of authority, top management makes a positive contribution to organization. Hoppe (2004), for instance, states that nations such as France may be respected and imitated by others for their culture. In the United States, Russia, and England, individuals tend to publicly commemorate *"macho"*- like military leaders, whereas in nations, such as Ireland, Australia, New Zealand, Canada and the German districts of Switzerland, those sorts of commemorations are uncommon (Hoppe, 2004). These last cultures are more egalitarian and therefore tend to give less stress to the role of leader. In an appearing sample of the lexical hypothesis (Hoppe, 2004), the assumed level of inequality or equality in the middle of leaders and subordinates is reflected in the language. For example, in the Netherlands, individuals in English language countries may be referred to as "*subordinates"* normally referred to as collaborators (co-workers).

The studies presented so far provide evidence that the extent to which leadership is defined or valued in different cultures is reflected in the historical and political implication that the term leader carries (Dickson, 2004). For example, a historical and political context has affected individual's perception. Therefore, leaders are Germany's

experience under Hitler. It is believed that using the term Fuhrer (the leader) has significantly dishonored the term leader in today's Germany (Bass, 1990; Den Hartog& Dickson, 2004; and Hoppe, 2004).

3.7. Leadership in Healthcare Environment (Quality Management)

Throughout the world, the healthcare service is attempting to offer quality healthcare to nationals while overseeing expenses (Walston, Al-Harbi, and Al-Omar, 2008). As Raja, Deshmukh, and Wadhwa assert (2007), healthcare organizations perceive the requirement to provide quality services if they want to survive as a healthcare provider expected to meet the psychological, physical, and social requirements of individuals seeking care. Quality is the center of most organizations as it is considered to be the primary business practice and competition. Quality management (QM) has become a strategic approach to attain superior performance and effectiveness. According to Raja, Deshmukh, and Wadhwa (2007), leadership involvement is fundamental and the most significant factor for quality management in providing a clear direction to employees' satisfaction. As noted by Antonaros (2010), leadership is about the behavior, skills, capacities, and knowledge fundamental for the accomplishment of quality initiatives, being critical given the number of organizations endeavoring to weave quality programs into their general strategic focus. Moreover, as Anderson, Rungtusanatham, Schroeder, and Devaraj (1995), and Laohavichien, Fredendall, and Cantrell (2009) claim leadership is vital to accomplish quality developments in services, product, and processes. It is believed that top management's commitment and involvements are essential to bring about quality improvement in any organization. Laohavichien, Fredendall, and Cantrell

(2009) point out that constant quality enhancement implementation and comparable strategies need a long-term commitment of some years in order to result in an effective consequence.

According to Bass and Avolio (1994), a remarkable aspect of successful quality management (QM) is leadership (Bass and Avolio, 1994). The Malcolm Baldrige National Quality Award's Criteria for performance excellence is probably the most generally utilized quality criterion for quality management. As noted by Idris and Ali (2008), one of the key classifications in MBNQA is leadership and it underlines the significance of leadership in accomplishing quality performance. In addition, this category underlines how top management can guide an organization and empower superior performance. Quality gurus also emphasize that top management is fundamental for effective implementation of quality management (Khan, 2010).

As indicated by Bass and Avolio (1994), the turbulent healthcare environment demonstrates that it postures challenges and has made organization aware of the requirement for appropriate leadership as healthcare professional role in an environment of uncertainty, ambiguity, and disorder. Academics point out that the current turbulent environment needs innovation, flexibility, and speed which traditional hierarchical practices are not able to adapt. Therefore, the right leadership in an organization can motivate an organization to articulate innovative opinions. These are identified as the *"strong forces"* of leadership, which can change the concentration from quantity to quality (Bass and Avolio, 1999). Quality can provide an institute with a competitive

edge; this aspect can account for the long-term success of an institute. Thus, numerous academics state the top management affects the quality environment. It is believed that quality management practices and concepts of leadership styles are extremely critical in organizations. The purpose of these ideas frequently determines how organizations accomplish their objectives (Khan, 2011). Despite the fact that these ideas are greatly related, they contrast in terms of their application and meaning in the organization. Although Goetsch & Davis (2011) claim there are many different ideas, the accomplishment of each of these methods in the organization relies on the working of the other; that is, when connected in a given institution, the two are seldom separable because they are intertwined.

A considerable amount of literature has been published on the perspective of leadership approach. These studies reported that the viewpoint of leadership theory focuses on an individual and collective dynamics (e.g., to combinations of interacting relations and settings). As noted by Uhl-Bien (2006), selected leaders are one voice amongst many in a greater corresponding social procedure. As indicated by Osborn, Hunt, Jauch (2002), and Osborn and Marion, (2009) a contextualized theory to evaluating leadership is comprehensively supported. Academics suggest that the context be included into the definition of distributed leadership (Bolden, 2011; Currie and Lockett, 2011).

As Fitzgerald, Ferlie, Wood, & Hawkins (2002), and Grint (2005) assert, in professionalized organizations, modification leadership is an ambiguous and intuitive procedure. As indicated by Bennis (2003), Ferlie, Fitzgerald, Wood, and Hawkins (2005),

Yukl (2006), and Contandriopoulos and Denis (2012), leadership is fundamental to changing organizations; and in healthcare environments, extensive consideration has focused on the role of leadership performed by medicinal hybrids in helped modification. Traditionally, research has focused on universal market trends, governance scheduling and the implications for new organizational structures in business Professional settings with less attention to leadership roles and individual change (Greenwood, Hinings, & Brown (1990), Hinings, Greenwood, & Cooper (1999), and Empson (2007). This principal point is reflected in healthcare, with focus on structural changes resulted from policy restructurings.

As noted by Mickan and Boyce (2006), in the previous 20 years new public management has been the main driving force of health care in institute reform. This restructuring suggests the employment of management purposes based on expenditure reducing and organizational capabilities in the delivery of healthcare services. New Public Management may oppose the traditional health care professionals' values of care and cure on which health facilities have been set up. In addition, it gives what could be clarified as an arrangement of conflict between the business of health and the practice of health.

3.7.1. Professional and Managerial Cultures

Culture may be defined as collective programming of the mind that distinguishes the members of one group or category of people from another (Hofstede and Hofstede 2005). Complex organizations like healthcare commonly contain many subcultures; for example, doctors and managers invariably form part of different cultures and structures in the same

organization (Thorne et al., 1997). Doctors operate in a collegial and professional culture. Control mechanisms tend to exist by mutual consent, influence is shared, and the most common source of power is expertise (Freidson 1988). Managers create role or task cultures based on order and bureaucracy or the tasks that need to be done. The differences between the professional and managerial roles draw attention to different expectations and cultural values of the different groups. Thus, when doctors go into management, they move from one cultural domain in the organization to another.

According to Mintzberg (1973), it is difficult to come up with one description of a manager. To illustrate complexity, Mintzberg (1971, 1973, 2004), states that managers have little opportunity and time to concentrate on intensive problem solving. Their works is characterized by large workloads, brevity, and discontinuity, and have to move from one issue to another and respond to interruptions while at the same time working effectively. Managerialism is a belief that organizations have more similarities than differences and thus the performance of all organizations can be optimized by the application of generic management skills and theory (Rausch et al. 2002). In contrast, to the manager's role, in the traditional clinical role, information is gathered and analyzed through reflection and previous experiences, and then utilized (Edmonstone 2009b) drawing upon a variety of approaches.

Professionalism has been a changing historical concept. Simple dichotomies of either professional autonomy or bureaucratic managerial control are inadequate to describe the complex and dynamic relations, which typify professionalized occupations. As a number

of commentators have noted, the word *"profession"* is today almost synonymous with occupation (Morrell 2003).

Elliot Freidson (1988) commenting on professionalism in medicine identifies autonomy as the characteristic central to professionalism, in that a profession is given the right to control its own work by determining that can do the work and how the work should be done. From this characteristic flows self-regulation (Exworthy and Halford, 1999).

Managers have a primary orientation to corporate success and ensure organizational survival (Exworthy and Halford 1999). Managerialism inevitably seeks to control and co-opt professional autonomy. Professionals are likely to insist on exercising and retaining the prerogatives of *"discretion"*. A major unresolved issue is the amount and form of regulation to be applied to professional practice and whether managers are appropriate and legitimate as regulators. Across the world, health care is under financial pressure and reform measures appear to be intensifying. There have been intense managerial moves to control the workforce such as devising ways to reduce control and supply of nurses by diluting the nursing workforce through creation of healthcare assistants and reduction of professional judgments for doctors to programmable routines (Harrison and Pollitt 1994, Iedema et al. 2004). This issue of managerial control of professional discretion has important consequences for social policy and political debate in the public sector (Exworthy and Halford 1999). What is not clear is the extent to which managers will be able and willing to use such developments to their advantage (Harrison and Pollitt 1994).

Fitzgerald and Dufour (1998) suggest that management of doctors by managers of their own profession may be more effective than being managed by managers from other professions. The fact that managers are either practicing professionals or of the professional origin may be argued to represent a continuation of the principle of professional control (Exworthy and Halford 1999).

Doctors and managers have different sets of objectives in accordance with their incentive structures and professional duties (Crilly and Le Grand 2004). Managers tend to stress the virtues of interpersonal skills, enlisting the co-operation of others and striving for a financial balance while balancing this with quality services. Doctors, in contrast strive for the best available evidence before making a decision with the aim of offering quality service, and rank financial break-evens as least important (Dopson 1994, Crilly and Le Grand 2004). There is therefore a fundamental conflict of interests on a social structural level (Dopson 1994). In their work on clinicians' perception of health reforms, Degeling et al. (2003) concluded that professionals need to accept that all clinical decisions have resource dimensions, recognize the need to balance clinical autonomy with transparent accountability, support the systemization of clinical work, and subscribe to the power sharing implications of team based approaches to clinical work.

3.7.2. Organizational Professional Conflict

Hoff (1999), Fawcett (1988), Schafer et al. (2002), and Aranya and Ferris (1984) point out that organizational professional conflict from the individuals' perception is practiced

by professionals, such as doctors and accountants while there is a conflict between their the organization's objectives and professional values. Individual emotional results of discord can result in lowered organizational commitment and low job satisfaction. Early research finding by Schafer et al. (2002), and Aranya and Ferris (1984) show that internal conflict may be discouraging for hybrid clinician managers, and may lead to high turnover amongst professionals, which is costly to the organization and consequently it can lower the quality of performance (Schafer et al., 2002; Aranya and Ferris, 1984).

The theory of organizational professional conflict has originated in the accounting field, which shows that the stage of organizational professional conflict is low amongst professional accountants functioning in accounting organizations. However, early research finding by Aranya and Ferris, (1984) demonstrates this discord grows because professional status inside the organization rises. Whereas accounting has mainly offered a proposal for the examination of organizational professional conflict, there is still lack of research regarding organizational professional conflict practiced by the medical profession members. However, this research study investigates if there is any conflict between leader's strategy and professional objective when implementation of quality management is in the process.

3.7.3. Organizational Role Theory

Examining role of hospital leadership in implementation of quality management requires a greater understanding of how role theory applies in the context of health. Early research finding by Biddle (1986) about classical organizational role theory emphasizes

on the roles that individuals enact in an organization that is hierarchical, pre-planned, and task oriented and thus, shapes a fundamental role in the attainment of organizational targets. As noted by Katz and Kahn (1966), work functions must be decided by the institute and accepted by each member in order for an institute to perform efficiently as a goal oriented social entity. The study by Katz and Kahn (1966) shows that the employee confers and consents a role that reflects the organization's culture. In other word, for the organization to function efficiently and effectively, the role must be efficiently communicated, completely comprehended, and acknowledged by its workers.

According to Lindbeck and Snower, (2001) changes in human resource management and philosophies and policies under new public management idea have realized workplaces progressively need workers to multi task, which contains workers accepting pluralist roles within the agency.

In summary, the definition of change leaders comprises individuals at any position of the organization with official responsibilities for change implementation, and those who informally support and encourage others to implement changes (quality management).

3.8. Leadership and Quality Management

The present research study draws from leadership theories, and quality management practical theories. Theories of quality management practices form the basis of this research study, particularly Anderson et al.'s (1995) theory that traced Deming's (1982) management method development (Rungtusanatham, Forza, Filippini, & Anderson,

(1998); Fisher, Barfield, & Mehta, (2005); Chowdhury, Paul, & Das, (2007). The review of literature shows that Anderson et al. made the first effort to synthesize quality management theory from Delphi method-based investigation, utilizing it with both academic and manager sources closely linked to quality. Anderson et al. (1995), however, claimed that in Deming's management approach, the fundamental reason is making an organizational system that encourages implementation of quality management practices involving continuous improvement, teamwork, and customer focus, all of which need effective top management.

As noted by Paul, & Das, (2007) the development of quality management practices and leadership theories share the mutual purposes of enhancing organizational performance and improving the work experience of organizational individuals. However, it is ambiguous what particular leadership theories are most efficient in institutes pursuing implementation of quality management practices. However, it is evident from literature review that leadership is a fundamental component in successful quality management in institutes, as all excellence models comprise top management as an enabling driver. Leadership includes long-term commitment to innovation and creativity. According to some scholars such as Laohavichien et al., (2009), human resources management is a strategic issue that needs managerial competence. They also believe that knowledge is a significant organizational resource, and top management plays a vital role in facilitating the attainment of that knowledge. Consequently, as Idris & Ali assert (2008) leaders must have the capacity to recognize framed vision by management quality components to transform the organization into utilizing quality managerial practices. In

additional, they underline this is feasible through a transformational leader who has the ability to direct and inspire his followers.

The scholars of this field have also recognized that top management support is fundamental for quality improvement (Laohavichien et al. 2009). Salaheldin (2009) agreed with this notion about an exploratory study on particular issues that Qatar Steel firm confronted in the implementing its quality program. The study pointed out that shortage of support from leadership was the greatest impediment to implementation of quality management. Once support and commitment from the leadership was approaching, quality management implementation led to an atmosphere of collaboration and brought about numerous positive outcomes, like improved management style, productivity increase, and quality improvement.

In addition to the significance of leadership in implementation of quality management, Deming anticipated that visionary leadership was crucial for a successful quality management program. Numerous research studies support the assertion that effective quality management needs leadership to offer a well-defined approach to subordinates (Laohavichien et al., 2009).

The significance of leadership is even emphasized in the Malcolm Baldrige National Quality Award (MBNQA) (Anderson et al., 1995). As noted by Pannirselvam and Ferguson (2001), there are strong connections between the diverse quality management constructs, and organizational performance, and quality management. They also point out

that leadership extensively influenced all organization parts whether indirectly or directly.

The investigators underlined that top management affects the production of organizational form and founds organizational practices for organizational survival. As noted by Salaheldin (2009) innovation is fundamental for attaining quality developments in service, product, and processes. This prompts worker satisfaction, which increases customer satisfaction and thus the hypothetical survival of the institute. However, what is required is not simply the company's survival, but rather quality management. According to Idris and Ali (2008), organizational leadership ought to be in charge of innovation, and not simply the company's survival.

A broader perspective has been adopted by Berson and Linton (2005) examining the relationship between top management and the foundation of a quality domain in research and development settings (R&D). They point out that both transformational leadership and transactional contingent-reward leadership lead to a quality situation in the R&D area of a communications organization. The role of transactional leadership is less imperative than that of transformational leadership. Transformational leadership likewise prompts employees' satisfaction. Top management needs to cope with unclear purposes and performance goals. As noted by Idris and Ali, transformational leadership, which contains inspirational leadership, can lead to various results in technology settings and have a surprising effect on the workers, thereby influencing quality.

Furthermore, Laohavichien et al. (2009) examined the impact of both transformational leadership and transactional leadership on a company's quality development. Through an investigation of quality management in the United States, the study point out that in spite of the fact that transformational leadership influences core and infrastructure quality management, transactional leadership does not influence either. According to literature review, so far, no studies have utilized leadership approach focusing on the effect on implementation of quality management practices; consequently, Laohavichien et al.'s study is critical. Top management influences subordinates and this improves quality procedures, services and performance.

With respects to the effects of leadership theory and quality management practices on organization performance, Idris and Ali conducted a study based on the experimental evidence from business organizations in Malaysia. They discovered that the capacity to adjust to change is basic to survival in the new worldwide economic request. This capacity, in the shape of transformational leadership, joined with the best practice ability, can lead to organizational success. On the other hand, a successful management method highly requires organizational change. As noted by Laohavichien et al. (2009), the transformational leaders build up the vision and through successful correspondence; they stimulate subordinates to accomplish that vision. However, transactional leadership has not been found to be of importance in quality development principally since this form of leadership is related to punishment and rewards and thus an exchange. Transformational leadership could affect quality management practices because top management plays the function of inspirations, which direct the employees.

A large and growing body of literature has focused on what practices can be termed under quality and which elements are in charge of quality development. Literature from distinctive sources, relating to diverse service and industrial segments and from distinctive countries has been reviewed. Most academics have highlighted the contribution of quality management to top management involvement and commitment. A great deal of previous research into quality management suggested that quality improvement is affected by several factors, including strategic planning, customer focus, employee relations, supplier quality management, process management quality and top management support. It is worth to point out that top management involvement and commitment, which most research studies have examined, are nothing but another name for leadership (Sila & Ebrahimpour, 2005).

Together, these studies indicate that quality improvement is directly related to leadership. However, from the literature, which has reviewed the role of leadership in implementation of quality management has attracted less attention, particularly in the complicated environment such as hospital. This research study considers the role of hospital leadership in implementation of quality management instead of the leadership style and their relationship with implementation of quality management.

To sum up, what the author in this area has sought to do has empirically confirmed that the qualities of the leader are extremely important for successful implementation of quality management. Rather than arguing that committed leadership is important for

quality management, the research goes further to delineate clearly the essential role of leadership that must be borne in mind by organizations in ensuring that adequate guidance is provided for the implementation of quality management process. The role of leadership and distributed leadership should be studied in implementation of quality management.

3.9. Chapter Summary

Lack of clear, consistent definition of leadership has resulted in a multitude of conceptualizations and theories, none of which fully encompasses what it is to 'lead'. This has led to problems for researcher to identify the role of effective leadership and subsequently measure the outcome of this success. Through a critique of the existing leader-centric theories of leadership, I have clearly demonstrated that leadership cannot be view as isolated, individualistic event, but as a social process. This process is embedded in social and organizational contexts, rendering traditional theories of leadership inappropriate when considering complex, pluralistic organizational processes. Distributed leadership approaches place leadership at all levels of an organizational system, encouraging informal leadership emergence through fostering a supportive organizational culture and system to networks to increase innovation. Whilst this approach would appear to be the most appropriate model of leadership to apply in pluralistic organizations, there are still a number of backgrounds to distributed leadership which have not been fully explored. Practically, more attention must be paid to the role of leadership in the organizational context, as it has not been clarified in depth. This chapter also reviewed the differences between private and public leaders and contingency theory

of leadership suggests that different approaches to leadership are appropriate in different situations. This implies a need to investigate whether leadership might work differently in the different contexts studied here or not. The chapter also reviewed leadership theories in organizational context such as healthcare and quality management. The next chapter reviewed the factors effecting implementation of quality management.

4.0. Introduction

Case study approach is the chosen strategy for researching the implementation of QM. Consequently, a research design is needed to link empirical data from particular research questions to desire conclusion is needed (Yin, 1994). Different approaches are applicable to address the research question; however, the required step is emerging a conceptual framework. The purpose of this chapter is to examine effective factors in implementing quality management. This chapter also develops a conceptual framework.

Moreover, the evolutionary part of quality management is identifying the significance of adapting a philosophy to suit context, approach, and firm's culture, and thus requirement for a '*contingency approach*' to implement QM. The quality management programs focused on technical *'hard'* tools including design of experiments. Over the time, the practitioners realized the insufficient attention dedicated to basic system's approach regarding QM. Initially, it is required to investigate the human side of quality. Such identification results in greater focus on the 'soft' factors including employee empowerment and teams. The researcher recognizes it as essential building block for implementing quality management. The following part reviews factors influencing implementation of QM and additionally considers external and internal factors. Afterwards, it discusses the evaluation of the theoretical framework. This research study

reviews quality management studies and leadership theories through major theoretical views on contingency theory.

4.1. Factors Influencing the Implementation of Quality Management

According to Oxford Dictionary, (2001) a factor is described as an effect contributing to an outcome, whereas implementation means the performance of carrying out, implementing or performing. Several writers such as Sila and Ebrahimpour (2003), Eyuboglu and Mellahi (2001), have analyzed the factors affecting the QM implementation in organizations. However, there is not enough research in the literature considering factors affecting the QM implementation in hospitals in overall and Iranian hospitals in particular. The scholar nonetheless is able to find some literature considering factors affecting quality management in organizations, some referring mainly to hospitals. According to AI-Haj (2006), there is no research on barriers of implementation ISO 9001:2000 standards.

The researcher commenced the procedure recognizing the factors affecting quality management implementation in organizations through taking notes from the relevant literature concerning these influences. The factors are divided into external and internal ones. The researcher reviewed the literature more when she felt it helps a better comprehension of these factors and their classification.

4.1.1 Internal Factors

4.1.1.1. Leadership commitment and involvement

According to quality leaders like Juran, Crosby, and Deming one of the most significant aspects, which affect the QM implementation, is leadership involvement (Tari, 2005). As Ennis and Harrington (1999) noted significant factors in implementing a quality management in the Irish healthcare system such as top management commitment, managing the organizational culture, teamwork, and the financial assets. Similarity, some writers found leadership commitment to be one of the most significant features of quality management best practices in Malaysian firms (Ab Rahman and Tannock, 2005). Leadership ought to play significant role supporting quality at every level in a firm. The chief executive officers is required to be "*champions of quality*" and be seen leading from the frontline.

Based on Brashier et al. (1996), when an organization begins the implementation of a quality management, the pivot point is the customer and the most critical elements included are leadership involvement, good planning, worker interest, cost management and physician support and involvement.

There is a large volume of published studies describing top management critical roles in facilitating and promoting the quality management implementation (Balding 2005, Banerji el al. 2005, Ruiz and Simon 2004, Mellahi and Euboglu 2001, Short and Rahim 1995 and Cheung and Koch 1994). Specifically, the leadership was discovered to prompt implementation of quality management by linking profitability to quality. Some writers

(Sultani 2005, Taylor and Wright 2003, Chen et al. 2004, and Ovretveit 1997; 2000; 2001) discuss that the commitment of hospital top management and employees at diverse levels is significant while implementing quality system and attaining hospital accreditation. Weeks and Helms (1998) believe that the process fails if leader provides weak support to the quality management effort.

Martin (2000) reviewed the implementation of quality management in 262 hospitals in 15 European nations and determined that the top management commitment in hospitals is required to attain an incorporated method to quality activities. Similarity, Schubert (1999) analyzed the QM practices in German hospitals. He understood important factors of success in the procedure of implementation were top and middle managers support, a combination of radical changes in chosen problem areas, and constant incremental development. Schubert also found the influence of staff education and training was an underlying factor of success in implementation of QM.

Based on Kanji (1998), leadership must be engaged actively in generating a complete quality culture with a well-defined vision adopting the following leadership roles:

- To outline a mission, vision and aims that promote a quality culture;
- To create a set of shared common norms that define a quality policy;
- To better organize the utilize the assets in order to develop financial performance;
- To set up goals and systems to improve customer satisfaction;

- To promote the improvement of human resources training;
- To connect, describe and motivate constant development.

Czuchry el al. (1997) also cite Latham (1995) disputing that vision is an vital factor in organizational success, adding that management ought to encourage staff to believe in the vision of the institution as a vital to successful change effort. Some writers, such as Thorsteinsson and Hage (1991), Campbell (1995), Mostafa (2004), Davis et al. (1997), Hoffman (2002), Chua and Goh (2002) and Sharp et al. (1997) have highlighted the significance of the organization's vision to attain the involvement and support of the staff in introducing change to the organization or implementing quality systems.

According to Ashire and O'Shaughnessy (1998), leadership must not just adopt slogans of developing quality; however, it should become engaged in quality efforts at planning, applying, and supervising phases. Leadership commitment supports supervisors, employees, and managers in an organization investing more totally in specific features for which they are accountable, thus, enhancing their influence on the quality of products. Top management should change their commitment into a set of activities aimed at quality development to compile and efficiently examine relevant information of customer concentration, supplier quality management system, and benchmarking. Without the support of leadership commitment, the behaviour of the employees is hard to change.

Some writes such as Munro-Faure and Munro-Faure (1992), Sila and Ebrahimpour (2003), and Yang (2003) have emphasized the significance of top management

commitment. In addition, Goetsch and Davis (2000) support the requirement to familiarize and interact the profits of the system for staff for continuous development. In addition, Beer (2003) emphasizes that implementation of QM will follow only if the leadership needs and institutionalizes an honest organization-wide discussion giving valid data about the quality management leading to changes in management quality.

The implementation of principles of QM and technical methods need managerial values, attitudes, quality of management, behavior and skills and making total quality management blossom over time. Besides the immediate difficulties of removing the gaps between reality and rhetoric, QM is a way of life if management deals with a number of problems unfolded during the implementation of TQM succeeds.

However, Sharif (2005) highlighted that leaders ought to thoroughly be aware of their duty facilitating the QM implementation systems in organizations. Abd Manaf (2005) claims that leadership commitment and involvement are vital factors to implementation of QM program in the Malaysian public health care system.

McFadden et al. (2006) highlight the role of leadership commitment in implementing QM and patient safety initiatives in US hospitals, concluding that the more commitment and stress placed on patient safety initiatives by the hospital leaders, the more likely the hospital is to truly apply them.

Overall, there seems to be a lot of evidence that top management commitment and involvement is a significant element in avoiding failure in implementing quality management systems.

4.1.1.2. Organizational Culture

A popular utilized definition of organizational culture is regarding the norms of organization as a set of common values among the staffs of that organization (Chatman and Jehn, 1994; O'Reilly et al., 1991). The values are divided into six categories: stability, innovation, respect for people, detail orientation, result orientation, and team orientation (Liu, 2004).

Based on Anwar and Jabnoun (2006), the general success of quality management is merely feasible if all its elements are implemented efficiently such as accessibility of the resources and managing the organizational culture, being a part of national culture, and adjusting suitable strategies. Homg and Huamg (2002) recognize that citizenship behavior and organizational identity could promote the level of QM implementation in hospitals in Taiwan. However, Beer (2003) claims that QM will persist just if the top management institutionalizes a spreading teamwork, and promotes transparent and effective communication, particularly in relation to QM data.

Boaden (1997) considers QM as a factor of cultural change, in parallel with human business process reengineering. Boaden’s opinions are supported by Scheuermann et al. (1997) and Mellahi and Eyuboglu (2001) who claim that for a successful quality

management, some factors such as top management commitment, training, employees' involvement, and organizational cultural management must be considered. While studying quality business implementation in UK organizations, Bauer et al. (2005) understood simple and informal structured organizations face fewer problems than those with formal and complex organizational structures. Based on Atchison (1992), the practical nature of hospitals creates a positive or negative organizational culture in work place, where a positive culture is made, where employees experience pride in their work, where each member is engaged in and committed to continuous development, where individuals freely support each other to reach goals, and where individuals feel appreciated during the process. While in a negative culture in hospitals, individuals spend some time guarding and defending themselves.

Other scholars like Claver et al. (2000), state the negative effect of bureaucratic culture in organizations and add that a bureaucratic culture has many unwanted problems for organizations including inappropriate planning, insufficient investment in technology, lack of employee involvement, hierarchical levels, unsuitable business alliances and an inability to adapt to the market. However, Awan and Bhatti (2003) emphasized centralised decision making, lack of quality culture, and high turnovers barriers in commencing QM system process in Pakistan. Furthermore, Chen et al. (2004) mention that incapacity to change organizational culture is one of the limitations to implementation of QM in healthcare organizations.

The study in a Middle East context by AI-Khalifa and Aspinwall (2000) investigated the bureaucratic culture prevalent in Qatari organisations, while cultural change and employee resistance to change were the main cultural barriers encountered in implementing QM system. AI-Kazemi and Ali (2002) also found employees' beliefs, values, and attitudes as affected by nationalities and backgrounds of employees. For instance, Kuwaiti nationals having deficiencies in technical competence, proper work values and career orientation.

Thus, previous studies have found that the most difficult barrier to implementing QM in hospitals has been their traditionally bureaucratic, highly departmentalized structure with its related cultural and leadership style. Similarly, Yang (2003) holds that the major barriers to implementation of QM remaining are linked to the traditional culture of hierarchical structures. As noted by Isouard (1999), QM includes a major paradigm change in the organizational culture; inherent problems existing in developing a quality culture do not come about without changing all employees' attitudes and behavior and guaranteeing the direct involvement and support of the top management. Likewise, Wilson (1997) asserts that main changes, attitude and behavior, are needed by the entire hospital system if QM programmes are implemented successfully.

As Yong and Wilkinson (1999), point out changing organizational culture plays a significant role in recognizing the success of QM implementation; however, because of competitive push for adopting QM, some leaders have largely disregarded fitting quality plans into their own organizational cultures.

Willoughby and Wilson (1997) in their research study carried out at the Cowie Group in the UK recognize the following cultural barriers:

- The employees consider QM as an approach that management could utilize to punish them, so a deep resentment is created towards the quality system.
- Fear of admitting mistake is the significant barrier to successful logging of complaints.

Considering some factors including sensitivity to the values, expectations, behaviours and relationships exist in every organization and enhance a good system (Pheng and Alfelor, 2000). The movement toward continuous improvement is associated with a need to change mentality and working through total commitment of top management.

Cameron & Quinn (1999); Twati and Gammack (2006) express that huge number of studies believe the most frequent reason regarding the failure of planned organizational change is ignoring organizational culture. Up to 75 percent of re-engineering, strategic planning, QM, and technology adoption efforts have generated serious problems through not identifying organizational culture as a key to organizational success and that effective leadership is the means by which the culture is generated and managed. Recognizing organizational culture is an imperative activity for leaders, because it influences strategic improvement, and efficiency (Schneider, 2000).

It has been suggested that successful implementation of QM needs the values of the organization is changed to harmonize them with the values of QM. According to Schneider, (2000), changing the values of an organization is not simple as they are rooted in the organization culture. Some authors (Drummond, 1992; Schildknecht, 1992 and Deming, 1986) believe that QM implementation must include cultural change of the organization. This sector of the literature covers the influence of culture on change management.

Based on Raju and colleagues (2008) enhancing clarification is an imperative pillar of QM and patient's safety in hospitals. Through technical and human challenges, organization's top management is stimulated to foster a culture of transparency, which leads to superior results.

4.1.1.3. Organizational Structure

According to Burns and Stalker, (1961), to explain mechanistic and organic organizational structure, two types of models are used. Traditionally, a mechanistic organizational structure exploits hierarchical and centrally controlled organizational relationships (Burns and Stalker, 1961; Daft, 2004), whereas an organic organizational structure has fewer levels and open internal structure (Spencer, 1994). A number of authors have considered mechanistic organizational structure a steadying effect on organizations whereas the organic one encourages adoptability and innovation (Eisenhardt and Tabrizi, 1995).

Organizational structure can support quality management effectiveness (Waldman and Gopalakrishnan, 1996; Cole and Scott, 2000). Shea and Howell (1998) suggest that quality management practices benefit from an organizational structure, which balances the need for control with the flexibility needed to respond quickly to the changing market. Douglas and Judge (2001) propose that organizational structure moderates the relationship between quality management and performance. Their research uses data from hospitals and finds some support for the moderating role of organizational structure. However, Douglas and Judge (2001) did not investigate the different orientations of quality management practices, and their conclusion implies that both high mechanistic and high organic structure positively moderate the relationship between quality management and financial performance. Therefore, their study does not provide insight into how to customize the quality system to match different contextual conditions. However, the study by Zhanga et al., (2012) argues that organizational structure influences the effectiveness of Quality Exploitation and Quality Exploration (quality management). Quality management practices that focus on exploitation benefit from a mechanistic structure since more hierarchical levels of the organization narrow the span of control. In contrast, an organic structure has more open and flexible internal relationships. This should benefit Quality Exploration practices that involve searching for new customers, learning from the latest technologies, and finding new ways to do things.

A large and growing body of literature has investigated that organizational structure can support QM effectiveness (Waldman and Gopalakrishnan, 1996; Cole and Scott, 2000). As noted by Shea and Howell (1998), the QM practices benefit from an

organization structure, balancing the need for control with flexibility required responding swiftly to the changing market. Douglas and Judge (2001) suggest that organization moderate and adjust the relationship between QM and performance. This research study utilized information from hospitals for the moderating role of organizational structure. However, Douglas and Judge (2001) did not examine the dissimilar orientations of QM practices, and the results denote that both high organic and high mechanistic organizational structure positively moderate the relationship between QM efficiency and performance.

Consequently, their research study did not offer insights into how to customize QM to match various contextual situations. However, according to Zhanga et al., (2012), organizational structure affects the efficiency of quality management. Quality management practices emphasize on a mechanistic organizational structure, as more hierarchical stages of the organization narrow the span of control. However, an organic organizational structure has more open and flexible interior relationship. The evidence presented in this section suggests the organizational structure is a significant factor needing to be considered in implementing QM systems.

4.1.2. External Factors

4.1.2.1. Environment Uncertainty

As noted by (Daft, 2004) environmental uncertainty means that decision makers have restricted information about environmental factors while having difficult time forecasting external changes (Daft, 2004). Environmental uncertainty has two scopes including

stable-unstable and simple-complicated (Daft, 2004). The stable–unstable dimension signifies how abruptly or dynamic the environmental components change. The simple-complex dimension implies the number and dissimilarity of external features and heterogeneity related to an organization's processes (Closs et al., 2008, 2010). The study regarding the operation management considered the stable-unstable dimension of environmental uncertainty (Benson et al., 1991; Sitkin et al., 1994; Bozarth et al., 2009), influencing operations in general and QM in particular. Some authors recognize the environmental uncertainty as the rate of process/product change, degree of competition, and change in customers' needs (Benson et al., 1991). Sitkin et al. (1994) recognize the sources of uncertainty: organizational uncertainty, task uncertainty, and product/process uncertainty. Mostly, the literature proposes three major sources of uncertainty connecting to QM: product/process change, competition, and customer needs (demand change).

Much of the available literature on environmental uncertainly has argued that environmental uncertainly affects the relationship between QM practices and performance (Benson et al., 1991; Sitkin et al., 1994; Nair, 2006). However, many writers propose that more research studies should focus on the role of environment about the efficiency of QM practices (Sousa and Voss, 2002; Sila, 2007). Environmental uncertainty makes it hard for associations to predict and reply to the future.

Since the external environments have a significant effect on implementation of QM, this research is located geographically and transiently in a specific environment. Comparing unstable social, economic, and political conditions in Iran as compared with

many other countries showed Iran is an appropriate case to be evaluated to deeply analyze the effects of factors on quality management implementation.

The previous parts discussed the effect of environmental uncertainty and organizational structure, culture, management commitment, and engagement on implementation QM. However, the structure of an organization does not rely on the environment, which an organization faces. Burton et al. (2002) extend a multi-contingency frame to understand how different factors influence performance (Burton et al., 2002). According to Siggelkow (2001), there are two types of fit – internal fit between the practices and the structure, and the external fit with the environment. Organizations that attain both high internal and external fit ought to have higher performance than those, which do not achieve both types.

Furthermore, this thesis has implications for QM theory, and thus this theoretical situation can be considered as the knowledge gap. Moreover, a comparison between the above-mentioned research findings and the outcomes of this research study as well as a deep discussion regarding the theory are provided in chapter 6 (Discussion Chapter). Although before gathering the data, especially for this research study, it is required to investigate different theories related to QM and leadership theory in order to choose an appropriate theory for this thesis. What follows is an argument considering theories and the choice of contingency theory as the theoretical framework of this thesis.

4.2. Evaluation of Management Theories for Selecting a Theoretical Framework

Olum (2004) defined theory as interdependent principles and concepts being grouped systematically to give a context to an important part of knowledge. In addition, Acharyya (2007) defines the theoretical structure as a "*structure that can hold or support a theory of the research work. It presents the theory which explains why the problem under study exists and serves as a basis for conducting research."*

Since each research study needs a theoretical framework, different theories are assessed for this research study. Choosing appropriate theories are the concepts of this thesis, which are leadership and quality management.

Contingency theory is the fit between an organization and contextual variables. Contextual variables include culture, environment, size, strategy, technology, economy, and policy. For any institution, the best organizational structure is one that constitutes the best accordance with these variables at a special time. This theory asserts that while managers make a decision, all aspects of current situation should be considered and based on those aspects, they must make a decision (Burns and Stalker, 1961). However, the affectivity of these implementations depends on the kind of hospital and whether it is public or private and its condition.

For this research study, different theoretical frameworks are assessed including various aspects of management (Han et al 2008; Pheng et al 2004; Gong et al 2009). These theories include various elements of management like interactions between human,

organization and society and quality. All these factors are connected to leadership and QM; however, among all, contingency theory was found to be the most appropriate theory of building the concept of this research study. Each of these aspects has its own significance for management of organizations; however, contingency theory was discovered to be the most appropriate theory (Zhang et al 2012), as it includes the concept of 'implementation of quality management', and 'the role of hospital leadership in this process' which is deeply associated with external and internal environment of the hospital which implement specific type of quality management.

Furthermore, while reviewing other research studies regarding QM, 'contingency theory' was the predominant theory utilized as the theoretical framework of some of this research show its appropriateness to the concept. The complementary discussion about the details of contingency theory in context of quality management is provided below.

4.3. The Development of the Conceptual Framework

4.3.1. Defining Conceptual Framework

According to Popper (1994), the research requires a theoretical research framework be a base for conducting observations, analysis and reaching conclusion. In this research study, the conceptual research structure was defined as a set of variables and their interrelations, in which a researcher emphasizes certain subjects evaluating a matter. Popper (1994) offers a critical review regarding the need for a theoretical framework as an essential basis for claiming. He *claims, "the doctrine that truth is relative to our intellectual background, somehow determines the framework within which we are able to*

think; that truth may change from one framework to another". In this point of view, the overlap between frameworks provides an opportunity to integrate streams of theory as a conceptual background before planning or designing the research study. The surveyors profited from this course. Consequently, for this research, presenting a conceptual research structure needs paying attention to appropriate concepts of the research topic and to the research methods connected to implementation of QM. These considerations remind the researcher of the significance of having detailed discussions about basic preconditions and assumptions, and the essential principles of theories regarding the research approaches in which a theoretical framework is consecutively developed.

4.3.2. Assumptions and Preconditions

The requirement for developing accountability for satisfaction of external customers or interior efficiency is generally regarded as a primitive and required motivation. Achieving and maintaining this motivation is significant in considering quality management (Benner and Tushman, 2003):

- **As a standard of excellence:** the thought of quality means a standard of excellence. However, accomplishing an excellence standard is not constantly motivating. Therefore, all the targets and efforts of attainment are designed realistically and accessibly. This standard of excellence is changed into QM principles including customer satisfaction, people satisfaction, and continuous improvement. However, these principles are actually various and may produce

practical paradoxes, yet the interest and leverage of most people ought to be accomplished.

- **As a reason to participate**: through accepting QM principles as a standard of excellence, the procedure in implementation of QM is objective based progress. This expresses that the performance of following a standard of excellence is constantly progressive. Some progress is essential for making gratitude as a foundation for generating participation. Therefore, the structure of implementation merely does not include defining, doing, and developing, but sustaining momentum for progress.

- **As consequences:** the consequences of following a standard of excellence regularly, like the display of participation, are contributive and productive in an organization actual sustainment.

- **As conditions:** following excellence, instituting contributions, and generating engagement (participation) need certain circumstances. The needed condition ought to be favorable in having positive impacts on implementation. If this condition prevails, then QM is considered as a worldwide method. The condition is strongly connected to the pressures or challenges confronted by organizations such as complex customer demands, excessive stakeholder expectations, people pressures from what they experience as dehumanization, and intense competition.

According to Takala (1999), these perceptions underscore the essence of ‘doing the right things in the right ways at the first time and continuously’. This essence is considered as the quality improvement conception. Implementing this perception into an institute needs specific clarifications of the terms ‘the right things’ and ‘the right ways’. The right thing is measured as the objective that creates the difficulty for achievement as the basis in realizing actions and building motivation. Benner and Tushman (2003), highlight that the right way has implications in performing activities. It contains actions of evaluation, measurement, and development as the core of procedure management (Benner and Tushman, 2003). In this respect, process management is a path of actions to follow what is directed by an implementation approach. Process management is needed to guide, control, and organize all labors for development.

According to Benner and Tushman (2003), the implementation program comprises attention to the subsequent expectations. These are considered as essential prerequisites for recognizing the quality development concept.

a. The organizational competence to fulfill objectives as a datum for defining successful implementation. This involves observing characteristics and conditions of customers, markets, competitors, regulations, suppliers, and stakeholders (including employees and investors). If an institute is uncertain of its objective, it is tough to emphasize goal setting and planning.

b. The organizational competence offers details about the circumstances. This competence can echo subjects of organizing and designing. Institutes can use the

quality award standard as an ideal foundation for self-assessment of their circumstances.

c. The organizational competence is to develop. This competence needs disciplined reaction and development mechanisms. Accordingly, the institute needs sustaining procedures, such as worker education and training, and information and interaction channels. Careful assessment of developments and self-experiences are beneficial for learning.

Building these competences is likewise the purpose of implementation of QM. If these capabilities are not completely built, implementation of QM becomes the objective. Subsequently, a strategy is developed. As the principles and concept could be new to an institute, building the principles and concept becomes a constant component of all the QMs and the essential circumstances. Based on these preconditions and assumptions, there will be a discussion about the research method before providing a theoretical structure for implementation of QM.

4.3.3. Approach in Developing Framework

Eisenhardt (1989) believes that an ideal case study of research ought to start with no theory to test. However, she accepts that considering a prior arrangement of the construct is significant, and that conducting research without conceptual basis is difficult to attain. In this research study, conceptual and theoretical foundations in the literature were studied. From the diverse methods for emerging a conceptual framework for implementation of QM performance, there are three broad kinds of approach aiming to

offer a rational consistency between empirical relevance and prescriptive idea (Yusof and Aspinwall, 2000a):

- Quality guru (expert) based. This approach is primarily taken from personal analysis and normative opinion through experiences in offering consultancy to institutes in the procedure of adopting a QM proposal.

- Award based. This approach is primarily for organizations searching for being recognized as leaders of quality management excellence, and likewise for self-assessment of their quality accomplishments for additional self-development.

- Academic based. This is mostly improved through academically based field research; commonly aimed at supplying contributions to theories in management, culture, organization, and perceptions.

Regarding the implementation of QM in a multilayered procedure, it is hard to develop a framework merely based on one of these kinds. According to Yusof and Aspinwall (2000), the quality leaders fundamentally do not built an implementation structure, rather they propose *"a prescription for companies to act"*, associating with this idea giving successful outcomes after a period of implementation. Regarding the disputes about the theoretical base in the prior chapter, the theoretical structure dedicates support to the award based and the scholastic based method. A suitable structure will hence be somewhere in between and, at best, includes elected features of those wide kinds.

According to Flynn et al. (1994), developing a conceptual framework is one of the centeral elements to the success of implementing QM (Flynn et al., 1994). A conceptual framework forms a skeletal building as the foundation for research study, and this implies that the framework can be a basic system, method, or structure (Bagozzi et al., 1991). There are slight differences between quality management implementation framework and quality management model, such as in the award-based method, because quality management can be considered as an objective and a process. The question *`what is quality management'* implies the ideal involving elements and concepts, and the *`how to'* question implies the implementation framework involving general ways to advance concepts and relationships. Regularly, a framework can be comprised of questions of *'why'*, *'what'*, and *'how'* as they signify the vision, motive (why), the plan and process, strategy, (how), and the system to be developed (what). In additional, the developed system comprises the structure to be developed (what and how), and the act for development (how and why).

Regarding the questions of what, how and why in terms of implementation, the three vital scopes of change as proposed by Pettigrew and Whipp are (1991):

- Content of QM. The components developed involve strategy and policy, process management, leadership, resources, and people. The content, moreover, includes activities (why and how) under a direction involving, business results, people development, and customer satisfaction.
- Context of organization and culture. How and why the external and internal backgrounds of an institute affect the procedure of implementation in

improving QM content directly or indirectly. Accordingly, the improved QM routines institute values, behavior, and norms as symbols of context.

- Process of implementation. How a change is made through processes (initiation, adoption and adaptation) towards anticipation (e.g. total quality management). The key substance in this change involves creating involvement, commitment, and participation.

These dimensions indicate an effort to comprehend implementation as a procedure of repeatedly constructing (how) and investigating the constructed (what and why as a purpose to performance).

Organizations require understanding of how to implement QM to attain the supreme benefit. Some scholars have recognized that taking one-size fits all approach to QM may not lead to best results (Sousa and Voss, 2001, 2008). Different organizations may require diverse approaches to QM. Different theoretical frameworks were evaluated for this study such as Six Sigma, and institutional sociological theories (Han et al, 2008; Pheng et al, 2004; Gong et al, 2009). These theories cover diverse aspects of management such as organization and society quality and interactions between humans. All these aspects are connected to quality management and leadership; however, among all, contingency theory was discovered to be the most suitable theory building the concept of this research study. This research study draws on contingency theory and empirically indicates that the contribution of QM practices to performance be contingent on contextual elements and additionally identifies the role of hospital leadership in this procedure.

According to Flynn et al., (1994), developing a conceptual framework is one of the centeral elements in the success of implementing QM (Flynn et al., 1994). Basically, a conceptual framework forms a skeletal building as the foundation for research study, and this implies that the framework can be a basic system, method, or structure (Bagozzi et al., 1991).

4.4. Contingency Theory

One of accepted theories to improve an organization towards productivity is contingency theory (Drazin and Van de Ven, 1985). This theory is a course of behavior theory that asserts that there is no best approach to managing an organization. According to this theory, leadership, an organizational structure, and decision-making style that are successful in some conditions, may be not effective in other conditions. Furthermore, the optimal leadership, and decision-making style depend upon different internal and external elements (Reid and Smith 2000, Chenhall, 2003 and Woods, 2009)**.**

Contingency theory is one of the main components in an institute that is broadly realized in examining the organizational improvement methods or implementation of management. Contingency theory in management studies and organizations claims that there is no one best approach to managing an institute. There are substitute approaches for diverse contexts to make examining an institute feasible. As Birkinshaw et al. (2002) claim many developments to organization and management are contingent on contingency variables such as expressions of the compound environment, indecision of a

presented technology or risk of a strategy. Contingency variables condition the connection between the content of the presented approach, the procedure of outline, and the predictable outcome.

In fact, management conditions have different justifications as to why particular management works well in several cases, but not in others. Scholars have recognized organizational and management existence is situational and these facts of organizational and management existence are what contingency theory has been developed from (Longenecker and Pringle, 1978). Kast and Rosenzweig (1972) have shown contingency theory within the context of organizational studies represents a middle ground between:

- Uniqueness of each organization and consequently examining each condition distinctively.
- Existence of widespread philosophies for organizations and management;

From the organizational viewpoint, the observed relationship is between organization and its effectiveness.

As Donaldson, (2001) states:

> *"The essence of the contingency theory paradigms is that organizational effectiveness results from fitting characteristics of the organization to contingencies that reflect the situation of the organization".*

Ritchie and Marshall (1993) classified the aim of contingency theory as two-fold:

- Determining the possibility of existence of relations between certain features in the environment of institutes
- Identifying different institutes' replies to these features in order to offer strategies for other institutes with similar situation

The emphasis of this research study is implementing quality management in hospital and stating that due to one-off nature of the hospitals, there is no one best approach to implement and manage them. Consequently, selecting contingency theory can be studied as a suitable theoretical framework for this research study as the core idea of this theory is in common with the emphasis of this research study; the contingency theory rejects the concept that there is one best approach for implementing and managing.

4.4.1. Organisational Fit Approaches

Contingency theory has been developed over time on methodological and theoretical grounds. According to Drazin and Van de Ven (1985) there are two key problems associated with the condition dependence idea of organizational fit founded on contingency theory:

- The organization contains interrelating factors, subsystems, and dimensions between which the certain relations have to be determined as conditions for attaining efficiency.
- The organization can be clarified straight by means of appropriate contextual elements, specifically, the technology and environment.

The concept of contingency theory was criticized by Drazin and Van de Ven (1985) in relation to these two problems, in which organizational fitting is studied as the theory whose strategy depends on the situation to succeed. Contingency theory is typically included in the range of propositions, so there is no straightforward generalization about implementation procedure in an institute. For instance, in developing countries, the introduction of QM lags behind the condition in advanced countries, and consequently, QM can be taken into account as a 'newly introduced management technology'. According to van Harten et al., (2002), in introduction of this new philosophy, two appropriate reflections are valuable:

- The progressive stages lead to the conclusion that there is no well-defined QM approach fitting each type of organization.
- The proposal of the QMS will depend on the pre-existing external and internal contexts.

Galbraith (1973) and Schoonhoven (1981) criticized the concept of contingency theory on the ground that it has difficulties such as shortage of transparency in its theoretical statement. As a result, theoretical statements fail to offer any clues regarding the particular form of the communication intended. However, appropriate contingencies and certain properties of QM have a vital role in the success of the implementation procedure. Contingency theory was found to be the most appropriate theory for this research study, as the focus of this research is implementation of quality management, and identifying the role of hospital leadership in this complex process, it has the power to

take the external and internal fit into account, which is considered as significant factors affecting implementation of quality management.

4.5. Contingency Theory in Context of Quality Management

As Zhang et al. (2012) noted organizations constantly examine new approaches to gain a competitive advantage and develop performance. Quality Management (QM) practices provide one method that organizations utilize to develop performance.

Firms require understanding of how to implement QM to attain the supreme benefit. Some Scholars have recognized that taking one-size fits not all method to QM may lead to best results (Sousa and Voss, 2001, 2008). Different organizations may require diverse approaches to QM. For example, should a commodity-based producer utilize the similar QMS as a high tech producer or not? One study by Westphal et al. (1997) examined implementation of QM in hospitals, and discovered that hospitals that customized the QM practices had superior performance than hospitals adopting standardized methods to QM. However, their research study did not offer a description about how institutes can customize QM practices. This research study draws on contingency theory and empirically indicates that the contribution of diverse QM practices is contingent on environmental contextual and factors organizational structure.

A number of authors have realized the significance of contingency theory in Operations Management (Lawrence and Lorsch, 1967; Thompson, 1967, Sousa and Voss, 2001, 2008). As research in quality management matures, researchers require moving

beyond justifying performances; they require comprehending the influence of situation (context) on QM practices. About implementing QM, *"recognizing the variables or conditions that have a dominant influence on the quality practice, quality performance connection could offer the academic and practitioner communities possible compelling responses to the issue of why sometimes quality development plans fail"* (Voss, 2002). According to Saad and Siha (2000), the procedure of implementation determines the content (as an expected achievement); however, the context is a moderating factor in this connection. Thus, either the context, against or supporting the procedure of implementation, is calculated as a given contingency for the implementation. Several researchers have commenced to improve a refined comprehension of QM through drawing on contingency theory. Foster (2006), for instance, reports the significance of taking a contingency theory view while implementing QM. This view is supported by Foster (2006), Sousa, and Voss (2008) who raise doubt regarding the "universal validity" of QM practices. They believe that the inconsistent functioning in implementation of QM can be due to contextual elements. Furthermore, several empirical analyses studied contextual elements that affect QM efficiency, for example, firm size (e.g. Ghobadian and Gallear, 1996; Ahire and Golhar, 1996; Sila, 2007) and country (e.g. Oliver et al., 1996; Rungtusanatham et al., 1998, 2005). A recent study by Jayaram et al. (2010) examined the influence of industry context, firm size, unionization, and quality program duration on implementation of QM. All the studies reviewed here support the contingency theory in implementing QM; however, they consider QM as a single set of practices. The study by Sitkin et al. (1994) suggests that researchers have considered QM practices as a single universal set of practices, though it does not allow customization.

However, some studies have highlighted the significance of customization (Westphal et al., 1997). Nair (2006) argues that future research should take contingency theory into account. Including the system approach in the contingency theory represents progress in understanding the reality of the process. In this case, however, the role of actors (e.g. leadership) can be interpreted as a contingency within contingencies.

As reviewed above, the contingency theory is the fit between institutes and contextual variables with the environment being studied as one of the significant variables for any organization and subsequently the quality management system which the organization implements. Thus, Iran – as an environment with clear distinct difficulties, has been selected as the case study for this thesis and the discussion about its situation was provided in details in Chapter 5 (Methodology). Consequently, based on Nair's view, contingency theory estimation should be considered as one of the processes of implementation of quality management (2006).

Due to the nature and conditions of contingency theory, the research questions of this thesis (investigation implementation of quality management in hospital and also the role of hospital leadership in this process) are best responded in relation to the contingency theory and through a case study that provides certain benefits for the concept of research study - Iran. However, discussion chapter involves arguments regarding contingency theory, its relation to implementation of quality management, plus criticisms of the contingency theory. Consequently, these views are observed across the case study and the results are offered in Discussion chapter.

4.6. Chapter Summary

This chapter reviewed the literature affecting factors in implementation of quality management. It also reviewed related studies and their findings, continued with evaluation of different theories and justification for choice of contingency theory as the theoretical framework of the research study.

The understanding provided by the literature review (chapter 2, 3 and 4) assisted the researcher to prepare the questions for the interview protocol. These questions are presented with the connected references in Appendix.

The following chapter, methodology, clarifies the undertaken research methodology including the research approach, research, and case study design. In addition, an in-depth discussion of Iran is presented. Furthermore, research strategy, data collection methods, and analysis methods are clarified.

Chapter 5: Research Methodology (Philosophical Perspective and Theoretical Frameworks)

5.0. Introduction

The previous chapter, literature review, covered quality management system, leadership theories and theoretical framework of the research. It examined the findings of other related studies. Finally, Different theories were assessed and contingency theory was examined as the theoretical framework for the thesis. Finally, the research questions were discussed.

According to Scott and Morrison, (2006) the research methodology offers the theory of how researchers attain information in their research areas. It also proposes a justification for the methods in which the researchers accomplish their research activities.

This chapter covers methodology, research design, and elaborating the study focus. This chapter further describes theoretical and methodological framework to conduct practical investigation. The next section, considers Iran and its social, economic, and political aspects as a case study and the reasons for choosing Iran. This chapter further covers the methods of data collection, process, issues of reliability, and the frame for analysis, before determining the ethical issues.

5.1. Research Methodology

The research methodology is an overall approach in which methods and tools of individual research are utilized to meet the given research goals (Adam and Healy, 2000). A clear expression of the research objectives is vital, as it enables choice of a suitable research methodology and data collection techniques. Zickmund (2000) finds methodology, as the processes for gathering and analyzing needed data. According to Yin, (1994), It depends on the overall research purpose and scope of the research goal, scope of the study, the perspective, the information, the research questions, the proposal, and restrictions of the research.

In summary, research methodology is the procedures followed by the investigator to develop her research. This process consists of recognizing the request for the research, revising the related literature, evolving the goals and questions of research, and eventually realizing the suitable strategies to respond to these questions. Furthermore, the methodology of research contains the tools utilized for gathering, analyzing, and presenting the information.

5.2. The Philosophy of Research

Based on Easterby-Smith et al. (1994), there is a long-standing discussion among the social scientists as to what the most appropriate philosophical approach is. There is no consensus among novice investigators about the best attitude to establish simple selections of methods to conduct the research. On the other hand, having a philosophical basis for selecting a research policy enables the researcher to have clarification,

concentration, and reliability in designing the research. Consequently, the researcher is obliged to have clear comprehension of the most appropriate philosophical state to derive a suitable research method.

Science methodologists are participating in a long-standing epistemological debate regarding how best to conduct research. The focus of this debate is on the relative value of two basically dissimilar (Amaratunga et al., 2002) and competing schools of thought:

- Logical positivism exploits experimental and quantitative methods testing the theoretical deductive generalizations. Positivism pursues the conventional methodical approaches toward developing knowledge, methods, interpreting results and research strategies.

- Interpretive science, that is Phenomenology, uses qualitative and naturalistic methods to comprehend human experience inductively and holistically in specialized contexts. According to Easterby-Smith, et al. (1994), more than searching for exterior causes and basic laws, this approach tries to catch a phenomenon concept. Social scientists are believed to appreciate diverse meanings and constructions that individuals place upon their experience (Easterby -Smith et al., 1994).

- To examine the strengths and weaknesses of two kinds of research philosophy and the nature of this research study, phenomenological approach was

selected. It is considered more suitable because it aims at an in-depth comprehension of change procedures, and of meanings and understanding of quality management processes in Iranian hospitals.

5.3. Research Approach

Qualitative and quantitative research methods are data collection methods in which the former is a source of well-grounded rich descriptions of processes in identifiable local settings (Amaratunga et al., 2002), examining the numbers instead of words, whereas in the latter the researcher focuses on the results by numbers not words (Hussey and Hussey, 1997). At one level, qualitative and quantitative refer to distinctions about the nature of knowledge: how one understands the world and the ultimate purpose of the research. On another level of discourse, the terms refer to research methods, that is, the way in which data are collected and analysed, and the type of generalizations and representations derived from the data. According to Ghauri et al., "*Qualitative methods are therefore more suitable when the objectives of the study demand in-depth insight into a phenomenon*" (Ghauri et al., 1995, p86). Qualitative research can also be adjusted by the changes, attitude, behavior sequence, and culture transformation (Dayman and Holloway, 2002). For conducting a comparison between these methods of research, their main characteristics are given in table 5.1.

Table 5.1: Comparison between Quantitative and Qualitative Research

Item	Quantitative	Qualitative
Role of Qualitative Research	Preparatory Means	Exploration of Actors
Relationship between the Researcher and Subject	Distance	Close
Researcher Stance in Relation to What is being Researched	Outsider	Insider
Relationship between Theory/ Concept and Researcher	Conformation	Emergent
Research Strategy	Structured	Unstructured
Scope of Findings	Nomothetic	Ideographic
Image of Social Reality	Static and External to Actor	Processual and social constructed
Natural of Data	Hard and Reliable	Rich and Deep

Source: Bryman (1998)

Quantitative research methods were originally developed in the natural sciences to study natural phenomena. Qualitative research methods were developed in the social sciences to enable researchers to study social and cultural phenomena. Both quantitative and qualitative research studies are conducted in healthcare. Neither of these methods is intrinsically better than the other; the suitability of which needs to be decided by the context, purpose and nature of the research study in question; in fact, sometimes one can

be alternatives to the other depending on the kind of study (Brysman and Burgess, 1999, p. 45).

Qualitative research is naturalistic; it attempts to study the everyday life of different groups of people and communities in their natural setting; it is particularly useful to study processes (Denzin and Lincoln, 2003 and 2005). According to Domegan and Fleming (2007), "Qualitative research aims to explore and to discover issues about the problem on hand, because very little is known about the problem. There is usually uncertainty about dimensions and characteristics of problem. It uses 'soft' data and gets 'rich' data'". (p. 24). According to Myers (2009), qualitative research is designed to help researchers understand people, and the social and cultural contexts within which they live. Such studies allow the complexities and differences of worlds-under-study to be explored and represented (Philip et al., 2000).

In qualitative research, different knowledge claims, enquiry strategies, and data collection methods and analysis are employed (Creswell, 2009). Qualitative data sources include observation and participant observation (fieldwork), interviews and questionnaires, documents and texts, and the researcher's impressions and reactions (Myers, 2009). Data is derived from direct observation of behaviours, from interviews, from written opinions, or from public documents (Myers, 2009). Written descriptions of people, events, opinions, attitudes and environments, or combinations of these can also be sources of data. The details of the qualitative methods used in this research are to be discussed in later sections.

Naslund (2002) asserts the distinctions between qualitative and quantitative research enable the researcher to decide about the suitable approach to meet the goals of the current research study (Naslund, 2002).

- The refusal of quantitative, positivist approaches through qualitative investigators.
- Through detailed interview and observation, qualitative researchers believe that they can approach the actors' roles and attitude more.
- More possibly the qualitative researchers are willing to confront the constraints of everyday life, whereas quantitative investigators tend to abstract themselves from this world and subsequently rarely study it directly.
- Qualitative researchers like considering that rich descriptions be valuable, whereas the quantitative investigators are less concerned (Naslund, 2002).

Based on Rossman and Raillis (1998), the characteristics of qualitative and qualitative research are as follow:

Qualitative Research

- It occurs in the natural world
- Uses multiple interactive and humanistic methods
- It is developing instead of being predetermined
- Is basically going to be interpreted

Qualitative Research

- Considers the social phenomenon as holistic
- It reflects about the study methodically
- Uses multidimensional inference

However, Lincoln and Guba (1985) caution that qualitative research, which is an approach that acknowledges the researcher's subjectivity, requires that the "biases, motivations, interests or perspectives of the inquirer" are identified and made explicit throughout the study (p. 290). Given below are some other disadvantages of qualitative research. These points are useful to the researcher such that he / she can try to minimise their effects during the course of the study.

- Researcher bias can bias the design of a study.
- Researcher bias can enter into data collection.
- Sources or subjects may not all be equally credible.
- Some subjects may be previously influenced and affect the outcome of the study.
- Background information may be missing.

In defence of qualitative research, Naslund, (2002) states that most writers suggest judgment should focus on whether the research is "credible and confirmable" rather than imposing statistical, quantitative ideas of generalisability on qualitative research.

To sum up this section, qualitative research is a systematic inquiry into the nature or qualities of complex social group behaviours by employing interpretive and naturalistic approaches. Qualitative study lends itself to thick narrative description of the group behaviours in the group's natural environment. It attempts to be no manipulative and takes into account the unperturbed views of the participants, as the purpose is generally to aim for objectivity. Qualitative research are most appropriate when the researcher wants to become more familiar with the phenomenon of interest, to achieve a deep understanding of how people think about a topic and to describe in great detail the perspectives of the research participants.

The qualitative research has been chosen according to the above-mentioned goals. Specifically, it was its close relation with phenomenological philosophy that lets the researcher explore the subject deeply.

5.3.1 Justifying the Use of Qualitative Research Methods

Leadership and quality management research is concerned with human beings, and any research methodology that uses quantitative research methods must recognize the variability that is inherent in human behaviour. Allison (1993) suggests that events, which form a phenomenon, are conditioned by interacting variables, such as time and culture, and as a result, no two situations are identical. As a result, the principle of scientific methods to the study of people is questioned, thus suggesting the suitability of a more qualitative approach. In support of this, Adinolfi (2003) advocate the appropriateness of qualitative methods in quality management research. They

emphasis that qualitative methodology allows one to investigate QM within its real-life context, to incorporate archival data critically and to understand the ways in which complex factors interact and generate real-life outcomes, as the subjective perspectives of the various organisational factors. However, before an epistemological stance can be adopted by this enquiry, it is necessary to identify the kind of data that is needed to test the hypotheses. It appears from the objectives of this study, that Implementation of quality management systems in Iranian hospitals with particular emphasis on the role of leadership, with much context to the data needed. Therefore, this suggests that the selected research methods must be able to take account of such factors, and acknowledge that many management decisions are idiosyncratic and guided by circumstances pertaining to the organisation. Clearly, 'rich' empirical data is required, therefore, the most appropriate' epistemological stance to adopt is that of interpretivism, suggesting the use of qualitative research methods.

Inductive and deductive reasoning are two general approaches resulting in obtaining new knowledge. The deductive reasoning is a theory-testing which generalizes and searches to discover if it can be applied to specific work; whereas Inductive reasoning is a theory established by specialized examples of observation and looking for making generalizations about the phenomenon under investigation (Hyde, 2000). The researcher chose the inductive reasoning, since it is a very powerful tool for giving insight into the results, making inferences, and drawing conclusions.

5.4. Research Design

The research design is the logical link between the gathered data and conclusions drawn from the preliminary questions of Yin's study (2003). Consequently, the main goal of research design is to respond to the research questions and satisfy the required objectives. It is a model proofing allowing the researcher to draw inferences concerning causal relations among the variables under exploration.

Qualitative researchers consider impossibility of assigning meaning to a phenomenon without understanding individual's situation affected by the phenomenon (Adinolfi, 2003). Thus, a qualitative researcher is pulled toward shrinking the meaning and understanding and obtaining a comprehension by a natural setting through observation and not measuring and qualifying the phenomenon (Weick and Daft. 1983). Ennis and Harrington (1999) mention that qualitative research is an in-depth study seeking to capture employees' views and identify possible inherent challenges and tensions in the quality management implementation process. In addition, Adinolfi (2003) emphasizes that qualitative methodology allows researcher to study quality management in its real form, incorporating archival data critically and understanding the ways in which interacting complex factors generate real life results at the same time, as the subjective views of different organizational factors. Yin (2003) lists different types of research designs including archive, experiment, history, survey, and case study.

5.4.1. Case Study Design

Qualitative inquiry often takes the form of a case study. Case study simply is an in-depth study regarding small number of instances of a phenomenon or a particular instance. Yin (1994) views case study as the preferred research approach when questions of *'why'* or *'how'* are being posed; in another words, questions of any process. Qualitative methods investigate beyond the time of events, people, or attitudes. Case study is a preference designed under certain conditions and problems.

Based on Mellahi and Eyuboglu (2001), a case study method is appropriate in early progress of research field, such a research in implementation of quality management system in developing countries at an early development stage.

Case study's main strength is that it permits the researchers focus on a specific sample or circumstance and attempt to identify mutual procedures while working. As it gives an opportunity to investigate a problem in-depth within a limited time scale, it is good for individual investigators (Bell, 1999).

Another strength of case study is its capability to deal with a full variety of evidence, documents, observations, interviews and artifacts, which are beyond what might be accessible in a traditional historic study. Alternatively, critics of this approach draw attention to some disadvantages including the fact that generalization is not likely questioning the value of single study of single (Blau at al., 1996).

From the current researcher's point of view, due to the exploratory and explanatory nature of this study and as it provides good practical evidence, case study is regarded as the most suitable research design. Robson (1998) proposes using case study accomplishes a rich comprehension of the context of the research and an enacted procedure. This is related to one of study aims investigating and analyzing the hospital leadership role in implementing quality management and the factors affecting the process of achieving

quality management system in Iran's hospitals. Since the research question is in the form of *'how'*, the use of case study is pertinent (Yin, 2003).

An additional discussion surrounding the case study methodology includes selection of multiple or a single study case and various levels of analyses (Eisenhardt, 1989: Yin, 1994). A key question in designing case research is the number of respondents.

The single case study is used to determine if a theory or hypothesis is correct or whether some substitutes of explanations are more relevant. Besides, it is suitable to utilize this approach while the case represents a unique case (Yin, 1994). Multiple case studies strive to get more generalizable conclusions than those offered through single case.

According to Yin (2003, p53), while choosing multiple case designs may be superior to a single one, two cases are better than one. Bryman has the same point of view considering that multiple case studies provide rich data and potentially increase the understanding of this subject.

In this research study, the focus is on implementing quality management process, related to influencing factors and outcomes. If the patterns correspond, the case study's internal validity will be amplified. In this research study, multiple case studies were conducted examining the developing model of process in different contexts

achieving external validity (Eisenhardt, 1989).

The researcher chose four hospitals (two private and two public) in two different cities to conduct the case studies. The reason for selecting both private and public hospitals is the literature suggesting that their leaders and managers have various perspectives regarding the research objectives. They have faced those factors influencing the implementation of quality management through process of quality management, from planning and design to full implementation. On the other hand, these four hospitals had implemented new type of quality management (Accreditation) recently, so the experience was still fresh to the participants. Besides, their leaders and managers might have different perspectives.

Table 5.2: Number and Type of the Hospitals Selected for the Case Studies

Type of Hospital	Kermanshah City	Tehran City	Number of Hospitals
Public	**1**	**1**	**2**
Private	**1**	**1**	**2**
Total	**2**	**2**	**4**

The biased view of case study is criticized by some authors including Diamond (1996); however, as recent research expresses researcher's bias may influence some other research designs or even data collection approaches and not only the case study. considers bias in experiment, and Sudman and Bradburn (1983) believe bias is influential in questionnaire for investigators.

Some scholars believe lack of reliability is one of case study disadvantages as it is poorly recognizable. When the researcher tried to reproduce a research or while other researchers want to do more searches about the same phenomenon, they ought to get the same consequences. However, as Yin (2003) expresses, extending a database for the case study while collecting data phases can be helpful to overcome this.

Because of the current study and in defending the case study as a real research design, it should be noted that bias is not associated with this research strategy. However, the

following sections (3.8. The Fieldwork) will explain how this research study seeks to minimize any 'biases. The criticism of result's validity and reliability regarding case study design is based on misconception of bias; therefore, it generally depends on the analytical skills of researcher to maintaining objectivity (Smith, 1990; Brown, 1998).

As factors affecting quality management, system and implementation of quality management process were about to be investigated in a country with specific environment, there was a need for a case study design in order to select a case and implement the research. Iran has a particular situation; it provides the environment in terms of politics, economy, and social and cultural setting. It is the nature of that setting in relation to the external world and current issues such as UN sanctions, which are producing this situation.

All economic sections are affected by this situation involving the healthcare sector. This specific situation of the country makes it a good case study particularly when it comes to the concept of implementation of quality management. The unit of analysis –the main point being analyzed in the study – would be the public and private hospitals and the study focuses on finding out the role of hospital leadership in implementation of quality management and how they manage quality in a highly uncertain environment.

This study also focuses on effective factors in implementation of quality management. As mentioned in the literature review, external and internal factors

would affect the implementation of quality management. What follows is an explanation about the characteristics of the country and the healthcare system, covering the reasons for choosing Iran as appropriate case for this thesis.

For the present study, the hospitals were selected from the public and private sectors, to see the differences and similarities between private and public hospitals. The hospitals were also selected from two different cities, one Tehran as a developed city, and the other is Kermanshah, a developing city.

5.4.2. Chosen Case Study: the Rational of Selecting Iran

This research study wants to look at the role of hospital leadership in implementing quality management and the role of the effective internal and external factors in implementation of quality management system. This research study seeks to look at external environment and internal conditions that affect implementation of quality management. Iran is highly an unstable country, which makes it a good choice. Furthermore, Iran is an interesting case that has highly developed and less developed cities and a mixture of private and public sector health care. In order to generalize how QM works across a variety of Iranian contexts, this research looks at public and private hospitals in a developed city and a less developed area.

Another reason for choosing Iran is that the researcher's home country provides a great opportunity for gathering required data about the environment. This present research will explore quality management system in a wide variety of contexts, which

in turn provides a rural, urban, private, and public comparison of the country. It is easier for a researcher to stay in the country for a longer time comparing it with other countries in terms of accommodation, cost and duration.

Iran's Geographical Location (United Nations, 2004)

Iran is located in southwest Asian and is bordering Turkey and Iraq from west, Afghanistan and Pakistan from East, Persian Gulf and Gulf of Oman from South, and Turkmenistan, Caspian Sea, Azerbaijan and Armenia from North (Figure 5.1). Its total area is 1.6 millions square kilometers and its population is around 70 million. Iran is

considered an oil-producing country and is ranked among world's top three natural gas and oil reserve owners. Oil sector supplies 85% of government's income and other economic sectors include natural gas, agriculture, construction, petro-chemistry, automobile, and industry (Library of Congress, 2008).

Healthcare sector can be considered as one of the important sectors of economy as it has a great contribution to development. The healthcare environment of Iran has faced difficulties especially in recent years. Social, economic, and political aspects of the country are considered in more details to justify the selection of Iran as a suitable case study for this thesis.

Society (Culture and Society in Iran)

Another reason for choosing Iran is that it is the researcher's home country, which provides a great opportunity for gathering required data regarding the environment. It was easier for the researcher to stay in the country for a longer time comparing the other country in terms of accommodation, costs, and duration.

Another interesting factor for possibility of conducting this research study in Iran was the authors' familiarity with the country's condition, society, and people. Knowing the culture and language makes communication and revising the existing documents easier and more reliable. Furthermore, the author had close contacts with the principals of Iranian private hospitals giving her the power to get comprehensive data. It also equipped the author with accessing different categories of people in each

hospital (doctor, manager, and head of department) being engaged in implementation of QM.

Economy

Iran's economy is based on oil. Therefore, any changes in oil price would affect the economic situation. Imposing different economic sanctions by the US due to political unrest between Iran and US, Iran endured many pressures. Besides, the newly one-sided sanctions on Iran forced other companies and countries not to have commercial relationships with Iran; other imposed sanctions by UN and EU have adverse and detrimental effects on Iran's economy.

There are some concerns about Iran's nuclear program and supporting terrorist organizations have intensified these sanctions, resulting in sharp decrease in transactions of Iran Oil Company and other international interactions. Based on a report by Congressional Research Service (2013), *"There is a sharp reduction in Iran's oil export by 1.1 million barrels-less than half per day during 2011"*. Therefore, due to Iran's dependence on oil export income; the economy has suffered from high level of instabilities due to recent sanctions.

Unstable economy has brought about high inflation and price instability. Besides dependency on oil incomes, other main inflation reasons include liquidity growth and dependency of Iran's central bank on government. Another important factor causing inflation is unsuitable control of oil income in which policy of monetary expansions has

led to the growth of liquidity and dependency of central bank (Dehnavi and Taherian, 2010). According to Congressional Research Service (2013), a decrease in oil revenue is coupled with deleting Iran from the universal banking system, causing a tough decline in the value of Iran's currency, Rial, and soaring the inflation up to 50%.

Hospitals confront much hardship in implementing quality management system because of different factors including unbalanced economy, high inflation, intense price fluctuations, cultural issues, and budget deficit.

Political

Political instability and non-democratic government in Iran have led to imposing international sanctions, which affect different angles of country mainly economy. Lack of specialized management is another reason to push Iran to the trouble. Also in some offices, the managers lack the necessary power and responsibility. Some factors influencing the management of hospitals include immigration of qualified managers due to mismatching or working in private sections or not being selected for the state sectors. Due to censorship, this rare information is regarded as a common knowledge of residents of this country.

From the statistics, there are 862 hospitals in Iran; however, this research study chose four hospitals (two private and two public) in two different cities to conduct the case studies. Based on Yin (2003) to select small-sized sample is a useful approach to accomplish some key differences regarding the large population although not sufficient to

represent the whole population. The reason for selecting both private and public hospitals is the literature suggesting that their leaders and managers have various perspectives regarding this research objectives. For instance, they have faced those factors influencing the implementation of quality management through process of quality management, from planning and design to full implementation. On the other hand, these four hospitals had implemented new type of quality management (Accreditation) recently, so the experience was still fresh in the minds of the participants.

5.5. Data Collection Methods

There are different ways to gather research data. According to Oppenheim (1992), research methods are defined as those used for data collection and generation. The data collection approaches used here is discussed in this section.

To validate the research, multiple sources of documents were used. According to Marshall and Rossman (1999), a researcher can use six main sources including documentation, archival records, interviews, direct observation, participant observation, and physical artifacts.

The same sources were listed by Yin (2003) whose evaluation advantages and stumbling blocks is given in Table 3.5. Based on Yin, different sources offer multiple measures of the similar phenomenon. *"Various materials are mainly complementary and a good case study will therefore desires to utilize the possible sources"* (2003 p85).

Table 5.3: Six sources of evidence - Strengths and Weaknesses

Source of Proof	Strengths	Weakness
Documentation	▪ Stable- can be reviewed repeatedly. ▪ Unobtrusive- not created as a result of the case study. ▪ Exact- contains exact names, references and details of an event. ▪ Broad coverage- long span of time, many events and many settings.	▪ Retrievability- can be low. ▪ Biased selectivity, if collection is incomplete. ▪ Reporting bias – reflects (unknown) bias of author. ▪ Access- may be deliberately blocked.
Archival Records	▪ Same as above for documentation. ▪ Precise and quantitative.	▪ Same as above for documentation. ▪ Accessibility due to privacy reasons.
Interviews	▪ Targeted- focuses directly on case study topic. ▪ Insightful- provides perceived causal inferences.	▪ Bias due to poorly constructed questions. ▪ Response bias. ▪ Inaccuracies- interviewee gives what interviewer wants to hear.
Direct	▪ Reality- covers events in	▪ Time-consuming.

Observation	real time. ▪ Contextual- covers context of event.	▪ Selectivity- unless broad coverage. ▪ Reflexivity- event may proceed differently because it is being observed. ▪ Cost- hours needed b human observers.
Participant Observation	▪ Some as above for direct observation ▪ Insightful into interpersonal behavior and motives.	▪ Same as above for direct observation. ▪ Bias due to investigator's manipulation of events.
Physical Artefacts	▪ Insightful into culture features ▪ Insightful into technical operation	▪ Selectivity ▪ Availability

Source: Yin (2003, p86)

To meet the objectives of this research study within the case studies, interviews and documents were chosen as the primary and secondary sources of information individually. Documents were reviewed during the interviews such as quality manual, minutes of meetings, organizational structure, and quality plan. Yin (1994) supported the semi-structured interviews.

5.5.1. Previous Studies and their Data Collection Methods

Reviewing the existing literature can be considered as one of the sources regarded for gathering the secondary data. This research study involved journals essays, books, online data sources and revising some documents such as procedure manuals, quality manuals, policy and self-assessment reports, assessment reports, external audit, and committee minutes. Reviewing and analyzing these data was used to contextualize the case study and strengthen the disputes in this study through supplying quantitative and qualitative evidences. It also assisted the researcher to analyze the gathered data from primary sources in-depth. After collecting the secondary data, previous studies were reviewed in order to select the appropriate methods for collecting the primary data.

Having reviewed other instigators' studies, a summary has been given below, amplification the purposes of each study in addition to the data gathering approaches used.

Abedalfattah Z. Al-abedallat (2012) has evaluated the effect of Quality Management Practices on organizational performance in Jordan. This research study empirically analyzes the extent to which quality management practices and organizational performance are associated, and how quality management practices influence organizational performance. Questionnaire was utilized to collect data from the banking area in Jordan (Quantitative).

Attal (2009) has evaluated the factors affecting the implementation of Joint

Commission International Standards in United Arab Emirates Hospitals. Data were collected from different sources containing cases studies, interviews, and documents (Qualitative).

Kima and Kumarb (2012) have examined the relationship between quality management practices and innovation. The objective was to examine the associations among different quality management practices and investigate which quality management practices relate to five kinds of innovation: administrative innovation, incremental product, radical process, radical product, and incremental process. This research study tests the proposed framework and hypotheses using empirical data from ISO 9001 certified service and manufacturing firms (Quantitative).

Zhang, Linderman, and Schroeder (2012) have evaluated how contextual factors influence the relationship between Quality Management (QM) practices and manufacturing performance. This study adopted multiple case studies approach to validate the result through replication. The data comes from a survey of 238 manufacturing plants in three industries across eight countries (Quantitative).

Studies reviewed above were some investigations regarding implementation of quality management in different countries, from different parties' perspectives. Having reviewed these research studies and their data collection approaches, the elected approaches for this research are explained below.

5.5.2. Interviews

According to Hussey and Hussy (1997), an interview is a method of data collection in which participants are required to find what to do, think or feel. It is a broadly utilized method of data gathering in social science in general, and in business and management research in specific (Yin, 1991).

There are three kinds of face-to-face interviews, including structured, semi-structured, and unstructured (Easterby-Smith et al., 1994). In the structured one, a set of predetermined questions are asked and the replies are recorded in a standardized schedule, while an unstructured interview is named an in-depth interview as it has no predetermined list of questions.

During the interview, the researcher had a list of questions; however, depending on hospital context and interview setting, they are different from one interview to another. The researcher has the flexibility to delete some questions in a specific interview or add others. The data were collected through interview, recording, note taking or tape recording (Yates, 2004). In addition, Saunders and colleagues (2002) state that semi-structured interviews are utilized in qualitative research not to uncover and comprehend what and how, but to put more stress to describe 'why'.

The interview lets the researcher to investigate complexities, ambiguity, contradictions, and processes (Yates, 2004). It also gives the researcher the chance to explore and discuss the likely definitions of questions and responses as interviewer

exploring the respondent point of view. In contrast, this technique is costly and time consuming, if a great number of respondents are to be asked. In addition, the interviewer may influence question's validity as influencing the interaction with the interviewee totally affects all the procedure. As the researcher has some connection with principal of private hospitals, it was easy to establish the needed support to make interviewees feel convenient giving the highest outcome and cooperation. This factor helped reduce the elapsed time while interviewing, as lines of communication exist between the researcher and interviewee.

Taylor and Bogdon (1984) note that the qualitative interview is flexible and before beginning the study, the number, and type of participants were not supposed to be determined.

Therefore, Taylor and Bogdan (1984) mention that in any study the sample size of the interview ought to be determined before doing the study. They also noted that the interview depth depends upon the number of participants. Similarity, Oberle (2002) modified that precise number of needed participants for qualitative study done cannot be specified before doing it. Following these suggestions, the researcher began the interview without knowing how many employees to interview, feeling that the majority of answers are repeated and enough information is collected to achieve the aims and objectives of research.

5.5.3. Documentation

Documentary data were utilized to verify and complement the interviews. Documentary data were possibly relevant to each topic of case study (Yin, 2003). This was a secondary tool to gather data through revising documents including quality manuals, internal audit, policy process manuals, self-assessment reports, assessment reports, minutes of meetings, organizational structure, and quality plan.

5.5.4. Justification of the Interview Method

As noted by Saunders et al., (2000) using interviews helped gathering reliable data relevant to the research aims. Easterby-Smith et al. (1994), assert that an interview is one of the most useful data collection methods in qualitative research. Yin (1991) also regards it as the most imperative data source in case study. Hussey and Hussey (1997) state that an interview allows higher level of confidence in comparing answers to questionnaire and can benefit from nonverbal communication.

Majority of qualitative researchers use in-depth interview, as collecting data through asking them is the best way (Yates, 2004). The current study persuaded the participants to talk about their ideas and their own level of understanding. Therefore, semi- structured interviews were conducted with top managers, middle managers, and general management staff. Using semi-structured interviews let the researcher obtain the required answers of interviews in a different way when a participant was reluctant to answer.

While composing interviews, the main source of data was tripled with documentation, in order to attain a broad variety of information on the same topic.

5.6. Target Interviewees

Amaratunga et al. (2002) quoting Kvale believes the purpose of an interview of qualitative research is gathering explanations of world-view of the interviewee regarding the interpretation of described phenomenon meaning. Top management interviewees, in the current research study, include quality improvement executives, heads of department, and senior managers. Middle management respondents included supervisors, doctors, nurses and managers. General staff' members included quality department staff, senior managers, section managers, and supervisors who helped the researcher to gather invaluable data about the process of implementing quality management.

The researcher began with an overall idea about interviewing individuals and how to find them (Taylor and Bogdan, 1984); however, the willingness to modification the goal after the initial interviews meet the research's aims (Taylor and Bogdan, 1984). In deciding on the suitable number of interviews, in each case study, 8 to 10 interviews were conducted. As indicated in table 5.4, two private and two public hospitals were selected in different cities (Kermanshah, Tehran). As Kvale (1996, p101) states, one should *"interview as many subjects as necessary to find out what he needs to know."*

5.7. Developing the Interview Protocol

According to Yin (1994), preparing a case study includes developing a case study, investigating the prior skills of the researcher, training, preparing for the special case study, and piloting of the protocols and data collection tools. The review of relevant literature on implementation of quality management in general and in hospitals, presented in literature review, allowed the investigator to comprehend the theories of quality management and to generate an interview protocol suitable to the research goals.

Having prepared a list of questions based on elements emerging from the literature review, a draft plan of the protocol was reviewed and discussed by the supervisors to improve the validity of matters. Several modifications were proposed and the rough-plan was modified appropriately through the adopted form.

The fourteen sets of interview questions were fundamentally designed to gather related information about the aims and objectives of the research study. The primitive questions started with defining quality from each interviewee.

The researcher continued with a question, *"What type of quality management do you use in this hospital?"* The researcher continued asking the next question when the interviewee stopped talking. The question was used to explore and discover the beliefs of hospital managers regarding quality management system. The main body of interview protocol was designed to gain a clear picture of the procedure of quality management implementation in the case study organizations and to attain a deep comprehension of

internal and external factors influencing implementation quality management and discovering the role of hospital leadership in this process.

5.8. The Fieldwork

The main activity of the fieldwork was paying individual visit to executive team members of four case study organizations. It was very significant in making trust and gaining support from the targeted respondents. The visits were mainly made to introduce the researcher and her study and present a letter asking for permission to do the research and ask leaders to encourage the respondents to cooperate while collecting data.

The researcher took the following stages to minimize the bias:

- Introducing herself as a investigator working on meeting the research purposes.
- Utilizing a neutral introduction when commencing the interview.
- Providing standardized interview questions.
- Summarizing the answers of the interviewees at the end of each interview and making sure the researcher comprehends the responses.
- Calling up the bias by triangulating the interview data with the collected information through official document making.

After the leaders of the four hospitals granted permission, the researcher held discussions with the quality improvement manager (the head of quality) in every hospital facilitating interviews with the selected personnel- using Snowball sampling method. The

approval was granted by the hospital manager to researcher to start the process of interview. Regarding the positions and roles within the organization, a list of potential candidates for the pilot and the actual interviews was improved. In general, 40 interviews were conducted in the hospitals.

5.8.1 Ethical Considerations

In the context of research, ethics refers to the appropriateness of researcher's behavior related to the rights of those becoming the subject of the work or being influenced by that. According to Cooper and Schindler (2008), ethics is defined as *"norms or standards of behavior that guide moral choices about researcher's behavior and relationship with others"*.

The researcher followed the policy of university considering granting ethical approval before conducting the interviews. The interviews were done at the most appropriate time for participations that were asked about the most comfortable times beforehand. The investigator customized her timetable and made herself prepare for each interview at the right situation before the planned time saving the time of the interviewee.

The participants were informed of the main purposes of the study before taking part in the interviews. They were told the aim of researcher was investigating and identifying the role of hospital leadership in implementing quality management in both public and private hospitals in Iran and being assured that any supplied information would be published or used unanimously. In addition, the participants were assured that their

information is kept confidential, and that they have the right to withdraw any time, and everything is based on their consent, and no one is deceived.

5.8.2. Conducting the Pilot Study

As Yin, (2003) noted the key objective of conducting a pilot study was to assist the investigator to review the plans of data gathering about to content of designed data collection instrument. According to Ghauri et al. (1995, p 66), *"a pilot study is the test checking the comprehending of the participant considering interview questions and the research problem, and such piloting of research supplies the main insight about what might be named the 'cultural endowment' of informants"*. The pilot study is carried out to determine credibility of interview protocol questions (Brenner et al., 1985).

Apart from the mentioned objectives, the pilot study provided the researcher an idea of questions' clarity and length, the time needed for the interviews and repetition within or between questions, permitting an opportunity to have feedback in case of any misunderstanding. This allowed her to revise and modify the questions before using the main case studies. In addition, the researcher believed that a pilot study would help develop more precise questions related to research objectives used while conducting the case studies.

The researcher conducted eight pilot interviews, two in each case study hospital. The interviewees included top and middle managers, and frontier employees from four hospitals. After recognizing the key points of research, the entire interview questions

were designed and produced based on literature review in chapter two. The pilot study continued from 15th of Dec. to. 27th, 2013. No major problems were recognized in interview protocol; however, the researcher paid attention to respondents' comments and ideas including some shortages like lack of clearness in some questions, repetition of the questions, their length, and finally modifying the questions.

New external factors related to implementing quality management, which were not stated in this literature, were recognized during questioning session. This proposes that these factors are specific to Iran's situation (imposed sanctions). The piloting of the interview questions assisted the researcher to change them and cover most of the related literature review. A neutral introduction was presented creating a comfortable environment during the interview avoiding any bias.

After finishing the pilot interviews, the researcher consumed a few days reading the answers, testing if the questions are reliable, adequate, and suitable to gather data needed. This procedure acts as a primary analysis of responses, in which the researcher's purposes are matched with them to make sure enough data are gathered from the actual interviews.

5.8.3. Conducting the Main Case Studies

The researcher commenced the actual data gathering on January 10th, 2014, conducting a total of 10 semi-structured interviews in hospitals A, B, and C and 8 interviews in hospital D. The interview was completed at the end of Feb. 2014.

Table 5.4: The Number of Interviews Conducted in Terms of Different Hospitals Type and City

Case	City	Public/Private	Number of interviews
A	**Kermanshah**	**Public**	**10**
B	**Tehran**	**Public**	**10**
C	**Tehran**	**Private**	**10**
D	**Kermanshah**	**Private**	**8**
Total			**38**

The interviews were conducted in offices in the hospitals either in the morning or in the afternoon. The interviewees chose the time and the place of the interview. Some interviews were conducted in English, whilst many were done in Farsi, the researcher's mother tongue, which enabled the interviewees to comprehend each word and expression during the interview. Finally, the investigator translated each report from Farsi to English. A professional translator as well as a linguist supervised all translations. During the interviews, the researcher recorded the respondents' voice and finally thanked all the respondents.

The average duration of each interview was 1.1 hours, some less or more. Depending on the busy schedule of respondents, two interviews were undertaken. Easterby-Smith et al. guidance (1994) was followed leaving enough time among interviews to write notes, think about data, and explore some raised issues. This required at least two hours after each interview. Therefore, while conducting interviews, each interview's voice was

recorded in a separate file and important points were written down. These files were useful while analyzing data as the researcher looked for similarities and differences between files. All interviews were transcribed as an MS word document, a process supported by other researchers like Stake (1995) and Yin (1994).

During the interview procedure, the researcher had an opportunity to gather other materials related to the case study including hospital documents, archive records, technical and administrative quality policies, and plans.

5.9. Analysing Data

According to Saunders et al. (2000), there is no standardized method analyzing qualitative data. Phenomenologist for example, resists categorizing or coding their data preferring to work from transcriptions or notes of interviews. Utilizing transcriptions or notes of qualitative interviews or observations by completely reading or re-reading them as an approach for analyzing these data (Saunders et al., 2000). The approach implemented in this current research study was to place the bulk of qualitative data gathered into meaningful and related classifications. This allows the researcher to analyze the data systematically and rigorously (Saunders, et al., 2000). In additional, Collis and Hussey (2003) describe how the answers are analyzed and then categorized into separate groups.

Flick (2002, P 176) differentiates *"two basic strategies conducting texts: on the one hand material's coding aiming at categorizing and/or developing the theory; and on*

another hand more or less strict sequential analysis of the text aiming at rebuilding the system of text of the case". Yin (2003) claims that overall goal of data analysis is treating the evidence fairly, producing forceful analytic conclusions and discarding substitutes interpretation. He (ibid, p109) states *"data analysis consists of examining, categorizing, tabulating, or recombining the documents addressing the initial suggestions of study"*.

Data analysis contains examining, classifying, or recomposing documents (Yin, 1994). As case study analysis, this research study utilized a pattern-matching logic, in which comparing empirical patterns is built from the gathered facts.

Content analysis is the approach used in this thesis analyzing the content of interviews. Content analysis is a research approach suitable for analyzing the documents; it uses a set of processes making valid inferences regarding text and quantifying content regarding predetermined classifications (Weber, 1990). Krippendorff (2004) defines the content analysis as *"a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use"*. However, it is not restricted to written material. It includes other things including images, sounds, and symbols. It is a scientific tool involving specific processes. Thus, it identifies body language and facial gestures in communications to better investigate people's opinions and evaluate them from psychological perspectives. Although the psychological aspect of interviewees' mentality and personality is influential in their responses, the expression of the codes and sub-codes was emphasized by the interviews.

The coding patterns were discussed in details in the interview analysis chapter.

Regarding the above disputes, the researcher followed the following steps to conduct data analysis:

All data gathered from the interviews or original documents were accurately referenced to the interviewees and were labeled. The labeling comprised the context and situations of data gathering, the date and time of the interview, and also the possible implications for the research study. The researcher converted the interview answers into computerized documents, and then grouped the data into categories regarding the models that emerged.

The researcher transcribed all voice recording into the form of written records ignoring all answers, which had nothing to do with the goals of the study. Moreover, the researcher changed any oral notes into the form of written records and disregarded all answers having nothing to do with the objectives of the study. Then, these labels were organized into a pattern of notions and classifications in tables, which sorted the information distinctly for each case study. At this step, numerous aspects and significant points were recognized. The researcher read and reread the results for better comprehension; later, she wrote the details of her results and utilized them to make an in-depth understanding.

The researcher rebuilt and restructured the data, thus recognized different patterns and categories regarding her in-depth understanding. This allowed her to delete, combine, rearrange, reorganize, and compare the data of each case study by putting them into the appropriate classifications and examining them systematically and powerfully.

5.10. Difficulties in Conducting the Fieldwork

During the data collection, the investigator confronted some difficulties, one was the fact that leaders were absolutely busy and it was difficult to secure appointments. To adapt their availability, the investigator had to spend a great deal of time; for example, it was essential to timetable some of the interviews early in the morning and late in the evening. Another challenge was that a few arrangements were cancelled since the interviewee had to be present in other meetings. Furthermore, the researcher was frequently kept waiting for a planned appointment, thereby wasting valuable time.

5.11. Limitations of the Research Approach

Determining the limitations of the research approaches utilized is very important. The main limitation was lack of literature related to quality management in health care, in hospital in general and in Iran in particular. Due to memory lapses, recording errors, and errors in interpreting the activities, events and nonverbal cues, the data gathered might be prone to the observer's bias (Sekaran, 2003). The key limitations imposed by the qualitative approach were the resources and time. So the extent of data was affected by the time available to gather meaningful data. Consequently, since there is no instruction as to how to collect a sample size in qualitative research, each scenario requires to be

measured in situation. In particular, the use of the semi-structured interview method possibly led to bias on part of both the investigator and the participants. This limitation was tackled by comparing the outcomes with official documents (quality manuals and audit reports). Introduction and standard interview questions also reduced the researcher bias.

5.12. Summary of the Chapter

To accomplish the purposes of the study, this chapter presented the methodology adopted. It clarified the choice of the phenomenological theory, a qualitative approach, and the semi-structured interview method, completely rationalized by referring to the nature of the objectives to be realized and the character of the research population engaged. An explanation of the fieldwork was offered to clear the information provided about how the data were gathered and analyzed. The following chapter presents the findings of the analysis.

If there were only truth, you could not paint hundred canvases on the same theme.

Pablo Picasso (1966)

6.0 Introduction

This chapter includes the analysis of collected data from Iranian hospitals, with respect to implementation of Quality Management System; it also presents and discusses the findings.

This chapter analyses the qualitative data collected through conducting interviews. The semi-structured interviews are selected as the main method for collecting data. In addition, number consulting reports have been selected as supplements, and some of the documents include minutes of meetings, newsletters and diverse reports. To meet the objectives of the research questions, the findings of triangulation of the two approaches are also presented. Why interviews were used as the main instrument for collecting data is explained in methodology chapter. These findings are analyzed and presented through four case studies. There are 38 interviews conducted in 4 hospitals. 10 interviews were made in each hospital except one with 8 interviews. The hospitals are indicated by letters A to D. The participants in the interviews in each hospital include the Head of the Hospital, Hospital Manager, Quality Improvement Manager, Head Nurse, and Supervisor. The Coding patterns indicated for each question from interviewees are offered in the Appendix.

The following sectors present a brief introduction to each case study, and the content of the questions is analyzed one by one. In addition, the required discussions provided through interviews in private and public hospitals in Tehran and Kermanshah are analyzed individually in the case of each hospital. The findings of the case studies (that are illustrated through diagrams) are based on statements quoted from the interviews regarding the implementation of quality management and also the role of hospital leadership in implementation of Quality Management System in Iranian hospitals. The similarities and differences in the responses are also presented for each case study. Finally, this research presents a figure for each interview question that ultimately summaries the findings.

6.1. Interview Results

The interviews were conducted from January 15 to May 31, 2014. On average each interview took 70 minutes. In the data presentation, the following abbreviations are used: CSA = case study A at Tehran Public hospital; CSB = case study B at Kermanshah public hospital; CSC = case study C at Tehran private hospital; CSD= case study D at Kermanshah private hospital. In each study, the researcher interviewed the Head of the hospital, the manager of hospital, the manager of Quality Improvement Office, the Head of each department, Head nurse, and doctors who had a managerial responsibility.

Table 6.1: The Number of Interviews in each Case

Case	City	Public/Private	Number of Interviews
A	Tehran	Public	10
B	Kermanshah	Public	10
C	Tehran	Private	10
D	Kermanshah	Private	8
Total			38

The researcher decided to interview the staff mainly responsible for quality initiatives in the relevant groups. This was conducted by concentrating on quality facilitators and directors in each group based on the presumption that they are informed regarding the features of the Quality Management Process. To identify the implementation of quality management and the role of top management in this process, the researcher also interviewed the directors of the hospitals and managers of each department. The interview questions were designed to collect in-depth information on key areas. The questions include:

- What kind of Quality Management do Iranian hospitals implement?

- What factors affect the implementation of Quality Management?

- What is the role of leadership in Quality Management in Iranian hospitals in both private and public sectors?
- What are the similarities and differences between private and public hospitals in Kermanshah and Tehran?

6.1.1 Case Study A: Public Hospital in Tehran (TCPUB)

CSB is one of the medical, educational, and treatment centers affiliated with Shahid Beheshti University of Medical Sciences with 31 years of medical practice. It is also one of the biggest public hospitals in the capital of Iran with the greatest number of emergency case patients. The hospital launched in 1978, has a capacity of 350 beds with 86 academic hospital specialists that provide service in diverse fields. Totally, it has 1400 staff working in four main medical specialties. The public hospital in Tehran is managed by a hospital director, directors of medical services, nursing, finance, administration, and clinical support services. The head of Quality Management in the hospital is also a member of the executive team and reports directly to the Hospital Director.

6.1.2 Case Study B: Public Hospital in Kermanshah (KCPUB)

Established in 1999, CSA is the biggest public hospital in the West of Iran with a capacity of 515 beds; it has hi-tech medical and research centers. It is also the busiest public hospital in the West of Iran in terms of the number of patients attending the emergency department (ED), special surgical procedures, available services, and variety of medical specialties.

KCPUB is managed by a board of chief executives and a Hospital Director. The staff members include four other directors, four medical services, nursing, finance and administration staff, and clinical support services. The Head of Quality Control in the hospital is a member of the executive team and reports directly to the Hospital leadership.

6.1.3. Case Study C: Private Hospital in Tehran (TCPRV)

CSD is the biggest private hospital in the capital of Iran (Tehran) in terms of bed capacity, available services, variety of medical specialties, and specialized operations. The hospital, launched in 1998, has 350 beds and above 200 specialized doctors in diverse fields. This hospital is an entirely private foundation, and is continually supervised by the Ministry of Health and Medical Education.

The hospital is led by a board of directors, a hospital chairman, other directors, managing director, and members of the board. The Head of Quality Management in the hospital is a member of the executive team and reports directly to the Hospital Director.

6.1.4. Case Study D: Private Hospital in Kermanshah (KCPRIV)

CSC is the biggest private hospital in the west of Iran (Kermanshah) in terms of the number of beds, the services available, the variety of medical specialties, and also specialized operations. The hospital launched in 1998, has a capacity of 215 beds and more than 200 specialized doctors in diverse fields. The total number of staff is around 2900. This hospital is an entirely private foundation and is continually supervised by the Ministry Of Health And Medical Education.

The hospital is led by a board of directors, hospital chairman, other directors, managing director, and member of the board. The Head of Quality Management in the hospital is a member of the executive team and reports directly to the Hospital Director.

In this section, a number of questions are presented to the interviewees. Given that the samples are presented in terms of geographical attributes and the style of management (e. g. public or private), the presented answers will be stated separately.

6.2. The Definition of Quality

The definition of quality is always taken for granted. Some interviewees have similar views regarding the definition of quality that is based on customer satisfaction. Some others believe that quality is a process, ending in effectiveness and efficiency; in other words, we should do well and choose well. In addition, quality could have different interpretations. Consequently, based on different individual, economic, social, and cultural contingencies, the concept of quality gains different interpretations. However, it could be generally maintained that there is no comprehensive definition regarding the concept of quality.

It seems that the difference is based on the level of what can be called one dimensional and multidimensional viewpoint towards the concept of quality. One-dimensional viewpoint maintains that there is just one criterion for the concept. For instance, in Kermanshah hospitals (private), there was such a viewpoint regarding the

definition of the quality of the services, and it was solely based on the satisfaction of the customers. However, in Tehran hospitals (both private and public), there was a holistic and multidimensional viewpoint towards the concept of quality. Therefore, considering the simultaneous process of planning, outcome and customer satisfaction, an important point is to maintain a multidimensional and comprehensive viewpoint on the concept of quality. In addition, there is a significant difference between private and public hospitals regarding their conception of the term. In private hospitals, the proposed definitions are concerned with hospital domain and medical activity. Another difference between private and public hospitals is based on the viewpoint of the managers regarding this concept. In other words, while in the private sector the focus is on customer satisfaction, in the public sector the focus is on government inspections.

6.2.1. Public Hospital in Tehran Case Study A (TCPUB)

A key point also proposed by most interviewees in Tehran public hospitals is the holistic view towards the concept. In other words, it regards quality not only in terms of customer satisfaction, but also in terms of including all processes. It is based on the requirements of the personnel, training programs, paying attention to the facilities and maintaining structural and physical spaces. Based on this view, only when all these considerations are satisfied, can we claim to have quality.

A number of definitions given in Tehran public hospital focus on quality cycle. For instance, one interviewee defined quality in terms of successful performance of the management processes. Based on this view, whenever the hospital performs efficiently, it

attains the desired quality. In this regard, quality equals perfection and growth, in which there should be a special attention to present and future affairs. The Hospital Manager shared this opinion:

> "*[Good quality means] benefitting from one process from the beginning to the end in order to get customer's satisfaction; that is, it is the customer that recognizes any process as of quality or out of quality."*

Another section of the provided definitions maintained a result-oriented viewpoint towards the concept of quality, an instance of which is defining quality in terms of the extent to which we get our predefined goals and needs desirably. The Quality Improvement Manager of the hospital said:

> *" To do the job right and correctly is to achieve the appropriate standard according to the possibilities and conditions"*.

Another part of the provided definitions contain customer-oriented viewpoint toward the concept of quality. One participant defined quality based on patient's satisfaction from the provided services. In other words, this viewpoint looks at the proportion to which the services ameliorate the problems, which the patients have.

Finally, a part of provided definitions focused on a standardized perceptive towards the concept of quality. In this regard, Quality Improvement Manager focused on the

standards that are levied by the legislators and international organizations. In this regard, the leader of Hospital stated that

> *"Quality is measured by the dedicated standards and criteria, designed by external organizations or internal experiences or different present methods; it requires collecting information and changing them to quantitative data that are measurable"*.

6.2.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The participants emphasized two significant points. The first was the interviewees' attention to the obtained information from the quality assessment, which was typically qualitative and needed to be changed into quantitative data. Consequently, to determine the gap between these two states, an accurate assessment could be done based on the present situation and desirable situation.

Several top managers interviewed defined quality in terms of the job satisfaction level, which has an abstract aspect. Based on this viewpoint, quality is related to the abstract issues and is regarded to analyzable statistically. Of course, it is worth noting that people with different cultural backgrounds can have different definitions of quality. Hospital Manager, in this regard maintained that

> *"Quality will be realized if some predefined necessities are in accordance with the organization facilities and abilities"*.

Other mangers defined quality in terms of customer satisfaction. In fact, customer satisfaction can be defined as the yardstick of quality. In this regard, the Quality Improvement Manager stated that,

> *"There are several definitions regarding quality. One of the theorists in this domain is Deming who defines quality in terms of the customers' needs and requirements. In his words, [It is] a process, which helps us to meet the customer's internal and external needs"*.

6.2.3. Private Hospital in Tehran Case Study C (TCPRV)

On the first level, the proposed definitions in private hospitals focus on the working method. In this context, most interviewees emphasized that such a definition varies regarding the job situation. An important point about proposed definitions in the private hospitals in Tehran is the multidimensional and comprehensive viewpoint towards quality that considers the process, planning, results, and customer satisfaction simultaneously. Another point in the proposed definitions is the consensus between interviewees regarding the final objective of quality as customer satisfaction. Quality Improvement Manager of the hospital maintained that

> *"Based on the activity of each department of the hospital, quality can have different definitions. For instance, in the nursing ward quality means the extent to which the patients are looked after. However, it has a different meaning in the department of the management, [which] can be termed [in terms of] attaining the predetermined goals"*.

Another section of the proposed definition focuses on customer satisfaction. As one interviewee maintained, customer satisfaction is the only yardstick based on which quality can be defined. Another part of the provided definitions had a holistic and comprehensive view towards the definition of quality. The manager of the hospital pointed out that

> *"Attaining quality is to provide desirable services to the customers according to a predetermined plan in order satisfy them"*.

6.2.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

A key point in the context of the proposed definitions is that all the interviewees in the hospital emphasized on concepts like satisfaction and effectiveness. In addition, they pointed out to the fact that quality needs to be recognizable in terms of a function. The proposed explanations in Kermanshah private hospital can be analyzed based on two perspectives:

The first perspective measures the quality only based on customer's evaluation. An instance of such a viewpoint was the opinion of a Head of a private hospital in Kermanshah (CAC):

> *"No definition of quality can ignore customer's satisfaction. Quality can just be inferred from the forms that the customers have filled out regarding the degree to which they are satisfied with the services that they have received"*.

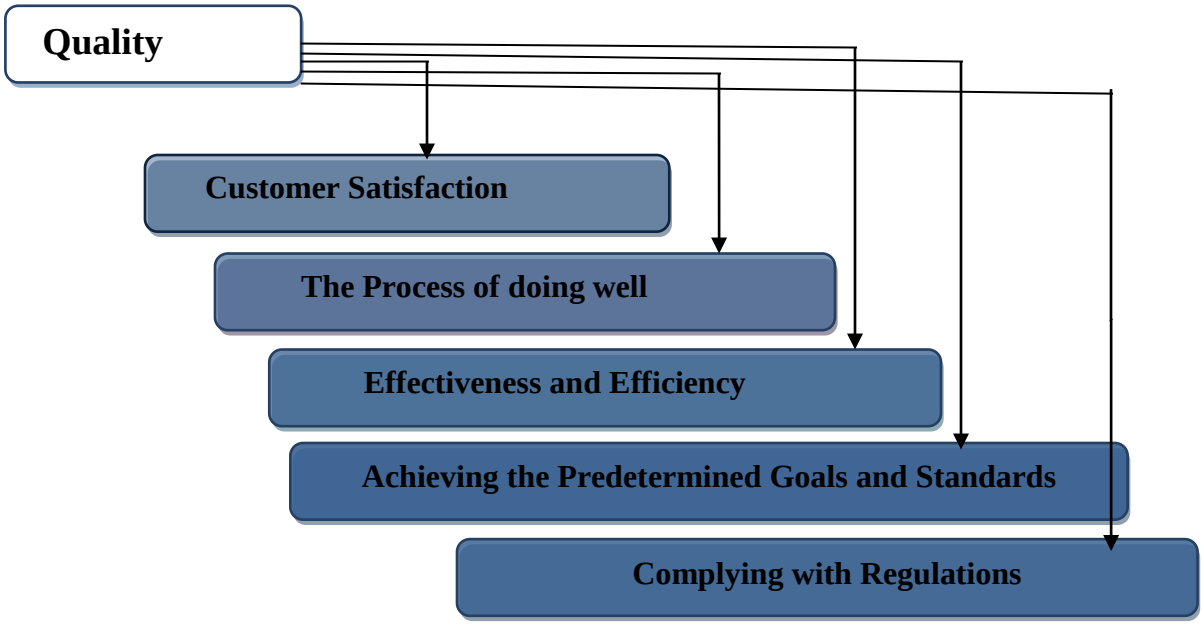
Based on the second viewpoint, the definition of quality is based on a result-oriented

perspective. One of the senior managers mentioned that

> *"Effectiveness means to identify a job as satisfactory if done efficiently. Being of Quality is to do job efficiently. Consequently effectiveness and efficiency are interdependent."*

The figure 6.1 indicates how quality is defined based on what appears most frequently of interviewee's perspective. Looking generally at the figure 6.1 it can be seen that the customer satisfaction was the most significant aspect of quality based on interviewees' perspective. Then the quality was defined as the process of doing well, effectiveness and efficiency, achieving the predetermined standards and finally quality is defined as complying the regulation.

Figure 6.1: The Definitions of Quality



6.3. Kinds of Quality Management Systems Used in Hospitals and the Ways to evaluate them

In the interviewees mentioned, all responds refer to an official document called Accreditation form. Generally, the directors of the hospitals viewed Joint Commission International (JCI) accreditation system as a tool designed to develop quality, patient safety and satisfaction. In addition, most interviewees underlined the role of the Iranian Governmental Strategic Plan in motivating (private/public) hospitals to achieve accreditation. The Ministry of Health orders the Accreditation System and all hospitals (private or public) are required to implement it. In this regard, there was consensus among a number of interviewees that Accreditation would develop the performance of the hospitals and the level of patient satisfaction. However, some interviewees objected that the Accreditation System would not to cover all hospital sectors. They also pointed out that the present system of quality management is incapable of monitoring all hospital sectors, i.e. there hasn't been a harmonized instruction for all hospital sectors. Consequently, Quality Management System (Accreditation system) needs to suit hospital's needs.

The similarity in the provided responses is the fact that most interviewees believed that compared with what has been released and decreed by the Health Ministry as a national formal system, when the hospitals implement their own approach of Quality System, it leads to more desirable results. In the past decades, most (private/public) hospitals had their own system of Quality; however, in the current years, Clinical Governance and Accreditations are decreed by the Health Ministry and all hospitals are

required to abide it. Clinical Governance and Accreditation are non-compromising systems based on which the hospitals are evaluated.

The next similarity in provided responses is that the decrees sent by the Ministry of Health and Medical Education does not consider all general, social, cultural, economic, and geographical conditions. In addition, the model of Quality Management System has been copied from developed European countries and USA without customizing (localizing) and coordinating it with the host country climate and culture.

However, the discrepancies among the responses can be due to lack of awareness, insufficient training, the pyramidal structure, and an inflexible hierarchical system that is most observable in the public sector. An outstanding difference between the private and public hospitals is that in the private sector focuses on a customer-oriented approach, while in public hospitals the emphasis is on working procedures (work-oriented approach). Another significant difference was observed in the Tehran and Kermanshah hospitals is that in public hospital emphasized on localization issue, which quality management system has been adapted, without localization, being implementation, but the Kermanshah hospitals believe that the localization of quality management system should be according to internal facilities.

6.3.1. Public Hospital in Tehran Case Study A (TCPUB)

A segment of the provided answers in private hospitals in Tehran refers to an official form called Accreditation. Most TM and MM interviewees underlined that there is an

official form called Hospital Official Plan, based on which all wards and sectors are obliged to keep and observe harmonized plans. However, as mentioned before, in recent years this plan is being decreed by the governmental system.

Primarily, the proposed responses refer to a special system called accreditation. Several interviewees stated Accreditation Quality Management System is a recent phenomenon. Despite the fact that hospital did a lot about quality improvement - as it was the case with EFQM (2002) and ISO (2009) - it wasn't compulsory to take Quality Management System formally into account, and consequently every hospital used its unique method to evaluate the quality level. However, since 2009 the Ministry of Science has attempted to integrate Quality Evaluation Validation in public and private sectors. In addition, it has tried to levy some standards, which were Patient Safety System (immunology), Clinical Governance, and Joint Commission International Standards JCI (Accreditation), which includes patient's Safety (immunology) and Clinical Governance. In this context, hospital's manager of quality improvement maintained that

> *"Quality is based on credit. Primarily, we got ISO, then Six Sigma and finally EFQM. Afterwards, the Patient's Safety (immunology) system at 2009, then Clinical Governance and finally Accreditation (JCI) which was decreed by the Health Ministry. Different affairs are performed in our hospital. While some processes require attaining measurement and indicators of quality standards, some are trivial and there is no standard for them, and are evaluated based on the satisfaction of the staff. Regarding evaluation validation, it should be kept in mind that all hospital forms are set up formally, and each form received from the upper*

headquarter is under hospital's control. After being completed, the forms are analyzed and then the results are evaluated in different committees".

Director of Nursing Services added that

"Accreditation is ordered to all medical centers by the Health Ministry. In addition, quality is surveyed by different models. We attained credit – dedicating via ISO, which determines whether our provided services are satisfactory or not. However, JCI system is obsolete because it is time consuming. Finally, considering the requirement for special tools and metrics for evaluation, quality cannot be easily measured".

The second group of the responses point to some recent services regarding Quality Management System. In this regard, several top managers interviewed stated that Clinical Governance and Accreditation are simultaneously in progress in the hospital in which they work. In addition, there are different yardsticks to evaluate Accreditation based on behavior and performance, such as year round personnel valuation and evaluation with respect to the coworker's mutual relationship. It also includes evaluations during the years that does not have a special system and are based on behavior, personality, performance, and some situational reactions. The leader of the hospital stated that

"Some standards are actualized; however, some are mere imitations from Western countries, which haven't been localized. Some of them are clear including Patient's Safety (immunology), Clinical Governance and Accreditation".

Based on the proposed responses in Tehran public hospitals, the first point to be made is that the totality of the decrees sent by the Ministry of Health and Medical Education (regarding Quality Management System) do not consider general, social, cultural, economic, and geographical conditions. The second point is that Quality Management System modeling has been copied from developed countries such as USA and European countries without being customized (localized) and coordinated with the host country's climate culture.

6.3.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The first point regarding the provided answers is the discrepancy among interviewees' ideas. Some point to a single system called Accreditation, and others pointed to many systems, which include Accreditation. It is worth mentioning that belief in a localized Accreditation system by the Ministry of Health is an essential pre-condition for the success of its implication. Some of the responses refer to a Quality Management System called Accreditation. The head of Training Department said that

> *"Generally, Accreditation system is a progressive issue. In addition, in this hospital, quality evaluation accreditation conducted in some of its aspects is standardized and some of its aspects performed are informal"*.

Hospital's Quality Improvement Manager holds that:

> *EFQM was performed in the hospital for a while but was immediately given up due to Ministry's lack of support. In addition, the Clinical Governance, which was performed, had 7 aspects and was based on some distinct domains. Accreditation*

system has 38 aspects and measures. Generally there are three evaluative Accreditations: Patient's Accreditation Evaluation, Clinical Governance Accreditation Evaluation and Accreditation Evaluation that have been performed since 2009.

The manager of Training Department maintains that:

"*In the past, there were many systems such as Six Sigma, EFQM and Clinical Governance. However, in recent years the system of Accreditation standards (JCI) has been practiced, in which we're obliged to keep some standards. We should do accreditation self-evaluation and transfer the result and policies to our audiences in order to raise the quality of the services in a wider range*".

Another section of the answers referred to necessity of Quality Management Systems. The leader of the hospital said:

Quality Evaluation Accreditation is implicated in different ways. While at times the main criteria is world standards, at other times national indexes are set as the main criterion. In this regard, sometimes our experience is a good yardstick to measures quality. In order to evaluate quality properly, we conduct two or three models. Based on one, we define the main processes from the beginning and designed them according to EFQM; however, since we work as a public hospital, we are obliged to act based on the policies of the Health Ministry. At present, the policy of the Health Ministry is based on Accreditation evaluating of quality. This system is adapted from non-Iranian models and has been localized (customized).

The difference between this model and the old one is that in the past we considered the standards, but the present system of validation, which is integrative, is localized and aims at reaching the maximum standards.

Director of Nursing Services added that,

"We have a number of models. We have a series of checklists and a series of customer feedbacks. First we implemented EFQM then the Ministry of Health decreed us that we should work on the Clinical Governance. After a year we were told that we had to do Accreditation (JCI). And it has been two years that we are implementing it. Accreditation has improved the quality and has created suitable feedback".

6.3.3. Private Hospital in Tehran Case Study C (TCPRV)

The significant point regarding the responses in Clinical Services System is that till recent years, in Iran, there has been no organized and harmonized system regarding medical Quality Management System. However, in recent years, the Ministry of Health has attempted to solve this shortcoming. According to most interviewees, when the hospital itself, tries to implement Quality Management System, it will have better results. The second point is the endeavor of private sector to supplement Quality Management System decreed by the Ministry of Health) in proportion with facilities along with the standards of the Accreditation System.

A Part of the provided answers in private hospitals in Tehran referred to an official form called Accreditation. Most of the TM and MM interviewees underlined that there is an official form called Official Hospital Plan that all wards and sectors are obliged to observe. Prior to being decreed by the Health Ministry, we already had some plans and operated some quality systems. However, in recent years, the Clinical Governance and Accreditation are ordered by the Health Ministry and we must implement them in our hospitals. Clinical Governance and Accreditation are unchangeable systems and the evaluating is performed based on them. Quality Improvement Manager of the hospital said that:

> *"Since last year an official form has been ordered for Accreditation, which is decreed to all hospitals regardless of being public or private. This form is an adaptation from CANADA's SIG & USA. Consequently, in some parts it is not yet been localized but we are obliged to keep it".*

The Head of hospital expressed that:

> *"We have a list of duties, which is based on supervision and control. Furthermore, we have an instruction by the Health Ministry that controls and monitors the quality of the services. In addition, there is Accreditation system (JCI) and Clinical Governance supervision. In fact, there are different informatics sectors, which set the main criterion for us to do the best. Consequently, there are formal and informal forms of quality evaluation".*

6.2.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

Knowing that Quality Management System should pay special attention to customer satisfaction, the first point to be made is the emphasis on necessity of customer-oriented system in a system of quality management. The second point is to pay attention to the job hierarchy avoidance of pyramidal structures regarding quality management. An effective Quality Management System requires a cooperative approach, in which all members are actively involved. Also, to obtain a better performance in the implementation Quality Management System, there should be an incentive based on job satisfaction . The third point is that some of the respondents had a professional viewpoint towards Quality Management System and focused less on the overall implementation of Quality Management System of the hospital. They mentioned it as an individual responsibility, which is informally assigned to them by their organization. Some of the provided responses refer to an official system called Accreditation. In this case, the manager of hospital's Quality Improvement Office stated that

> *"This hospital is evaluated by the Ministry of Health and Medical Universities of all provinces. In recent past, there have been checklists to collect and gather data; however, according to the Health Ministry's 5-years plan, at first it was based on Clinical Governance that had seven aspects. Then the immunology (safety) standards was implemented, and now the Accreditation System, which is going to be applied. Being [comprised] of 38 aspects in a group of measures and metrics indexes, the emphasis of the present Quality Management System is mostly on Accreditation System. For instance, one of measures is comprised of a series of methods and approaches that is determined by the departments. In*

addition, the sectors are prepared with the assistance of Quality Development Office, and are ordered to affiliate sectors by the hospital Manager".

Another section of the provided responses referred to an integrative system of quality management. Several TM interviewees claimed that every Head of hospital primarily uses a set of subjective information as managerial indicators. This information is obtained based on the survey forms filled by patients, personnel, and Preparation Departments. These indicators can be beneficial for the manager in terms of short-term, mid-term and long-term planning with respect to human resource, equipment and financial resources. The manager of Quality Development Office believes:

"They apply an integrative and combined system. It seems that this system has stronger emphasis on the customer satisfaction because customer satisfaction is an important factor for this hospital. The reason for being cooperative is that the top senior management always benefits from the critical opinions. Besides, all the levels of management maintain a good relationship among each other. Consequently, the hierarchical system is not kept and the system is managed open-mindedly".

Some of the responses referred to individual responsibilities and informal system along working with Quality Management System. The manager of the Nursing Department said that

"In the morning, they visit all wards and ask patients about the quality of the services. If one of them is dissatisfied, we'll looks for the reasons. In addition, an informal form is used for evaluation. But we have some indicators too, for example there are checklists in all wards and sectors for evaluation".

The Emergency Technical Manager added that:

"Since our training methods and sources are affected by an American method, it is applied and is tried to get localized. This system, which focuses on customer satisfaction, is run daily and all the nurses are asked about patients' situation. Consequently, in the private sector the emphasis is on customer-oriented system".

The figure 6.2 is based on interview responses, and shows how Quality Management Systems have changed over time. Based on the timeline of quality management, the historic profile of Quality Management System indicates that since 2005 to 2016, more than six QMSs have been implemented.

The second figure 6.3 is designed based on the evaluation of Accreditation as quality management system. As identified by respondents there are some positive and negative aspects associated with accreditation in quality management. The figure shows that Quality management system has brought about positive changes (for instance improving the hospital work procedures, services quality, and presenting a feedback to management about quality management system) in the Iranian hospitals. However, the figure indicates that there are some negative points associated with quality management system, which

include lack of native program of quality management system in accordance with the type of every region's cultural, social in Iran and also lack of possibility to change of accreditation system.

Figure 6.2: The Timeline of Quality Management Models

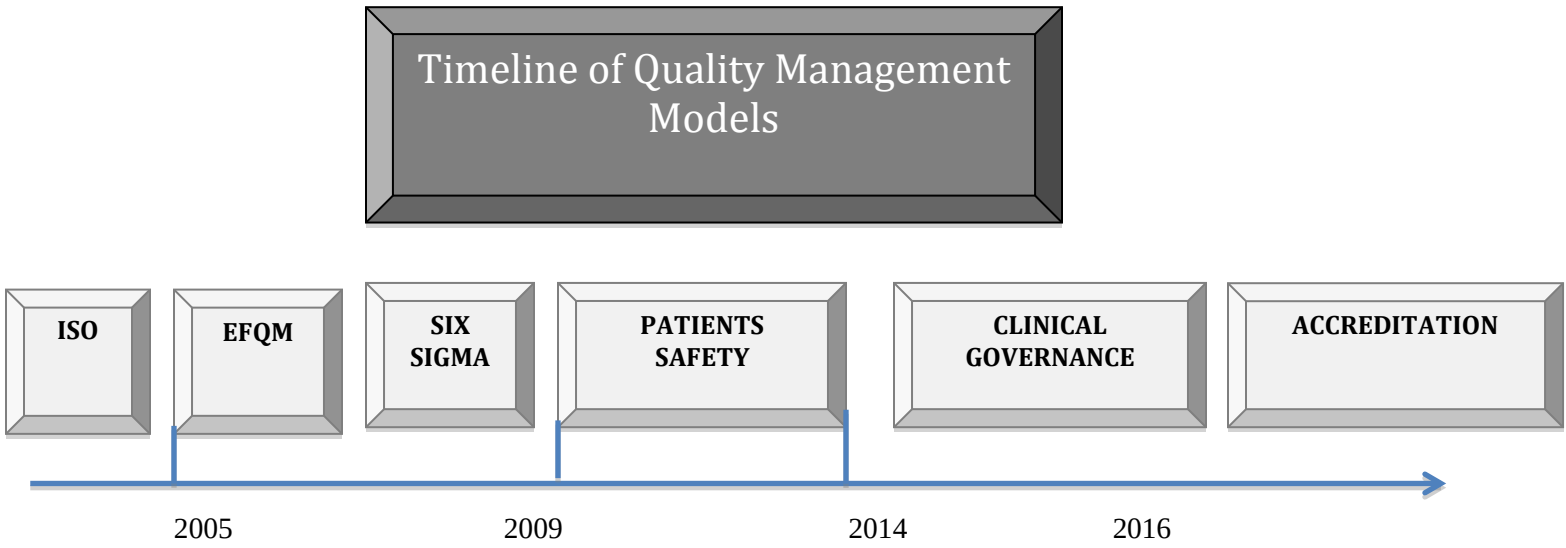
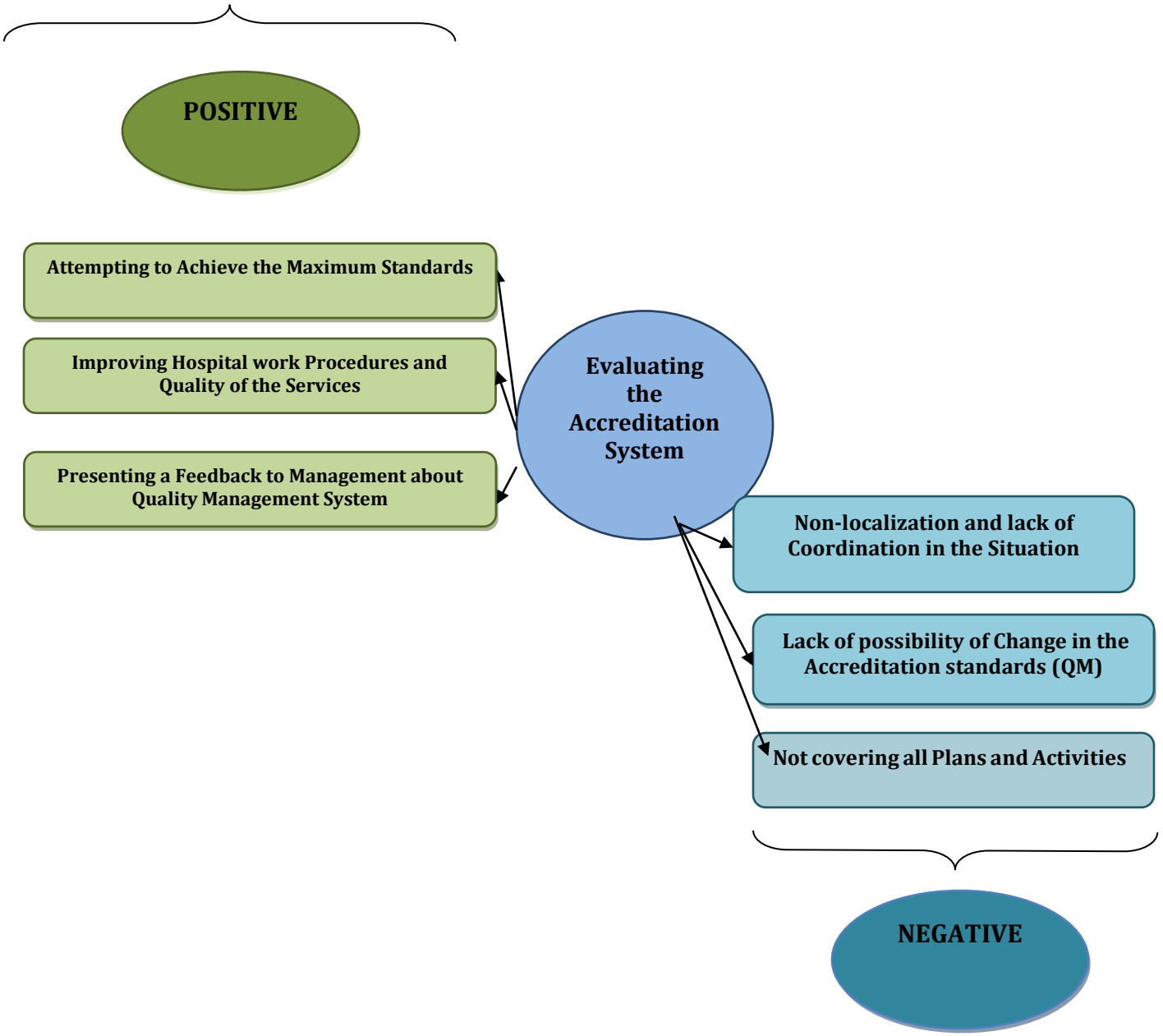


Figure. 6.3: Evaluation of the Accreditation System in Hospital



6.4. The Affective Roles in Implementation of Quality Management System

A similar structure was observed in the private and public sectors regarding the role of the individuals concerning the implementation of Quality Management System. A number of interviewees stressed that they just formally implement Quality Management System and do not have an active role in it. In other words, they are solely the performers of Quality Management System. Being in the first line of commandership and official hierarchy and being obligated to perform and achieve the ordered plans of Quality Management and as an executive, the interviewees have no productive role in designing Quality Management System. In addition, another similarity was crediting hospitals based on the extent to which they can implement Accreditation; in other words, the extent to which the hospitals earn credit and budget depends on the extent to which they are successful in implementing Accreditation System.

A significant difference observed in the private and public sectors' focus on Accreditation System was due to the role of people in the implementation of Quality Management System (Accreditation). In the private system, criticism is directed towards the limited role of hospitals and personnel in Health Ministry's system of macro plans. This system limits the private sector by ordering the plans and obligating the hospitals to apply them. Consequently, it prevents designing an organized plan in the context of Quality Management System based on a customer-oriented road map.

6.4.1. Public Hospital in Tehran Case Study A (TCPUB)

An important point regarding the provided answers is the difference in interviewees' responses and point of views regarding the extent to which they are affective in Quality Management System. Some maintain that they are just performers of the program; on the other hand, another group claims that they have wider and more affective roles such as being trainers, surveyors, etc. Maybe one to the reason for the conflict in which a single organizational chart is set for different posts is the overlapping of the responsibilities.

A majority of interviewees in their responses stated that they are just the formal performers of Quality Management System plans. Being obligated to perform and achieve the ordered plans of quality management as an executive or coordinator, they complained that they have no role or effect in designing Quality Management System. The nursing department manager explained that:

> *"As a performer in nursing group to implement Quality Management System, I along with my coworkers have supervisory, performing and coordinating role. However, any person can have an effective role in Quality Management System according to his /her job"*.

The hospital Quality Improvement Office Manager stated that:

> *"Our department (Quality Management Office) tries to apply Accreditation system standards in hospital. In fact, it plays an important role"*.

Unlike the responses mentioned above, the other group mentioned that they have other responsibilities in addition to what has been formally assigned to them in the implementation of Quality Management System. This difference in responses with the first part can be due to organizational posts. In this regard, the leader of hospital said that:

> *" The most important role of hospital focuses in medical affairs, especially in training-treatment hospitals. Being up to date is the main issue. By being so and also by considering the situations, we can update the plans, activities and services".*

6.4.2. Public Hospital in Kermanshah Case Study B (KCPUB)

A group of interviewees said that as it is the case with Tehran public hospital, in Kermanshah public hospital, the plans of quality Management System are being decreed formally and are just performed and executive based on the formal obligations. In this regard, the organization gives the staff little authority and will to make them involve in creative designation of the plans. As a result, this responsibility is often ignored in organizational hierarchy. The hospital's Quality Improvement Manager said that

> *"They do the ordered plan then they monitor its implementation. They have to supervise and investigate the results. Of course, this is done along with external evaluation and then both results enter into the evaluation system. Finally, defects and deficits are identified, and they try to improve their plan. The role of this office is to be the executive, coordinator and supervisor, and it was set up two years ago".*

The Quality Improvement Manager added that

> *"We are the main office in terms of implementing Accreditation program. Since we work in Quality Improvement Department, we investigate the cases. In addition, in relevant committees we survey many relevant issues regarding Quality Management System"*.

Another group of interviewees had a theoretic and attitudinal viewpoint regarding their role in Quality Management System. In their presented responses, they expressed that having belief is the main prerequisite to consider Quality Management System, which can improve not only the whole system but also people's role in it. If it exists, it will be conveyed to other people and consequently there would be better outcomes. The leader of hospital said that

> *"Primarily,* the *manager's role is to believe in quality management. This is the most important issue, especially in situation that the process is performed in teams and groups. According to our perspective, in a big corporation, quality should echo in all levels of organization. Consequently, top managers' belief in Quality Management System will encourage other personnel to apply the determined standards"*.

Another group of interviewees focused on their domain of activity and believed that they should pay more attention to every person's role in Quality Management System. They also pointed out that everyone, according to his/her role in Quality Management System should redefine this question. The director of medical affairs concurs that:

"One of the main issues that is defined in the national standards format (and hospitals are obliged to observe it) is the existence of the people whose payment is based on monitoring the level implementation of the quality plans. This person is responsible to get entries, data supply, analyzing the present situation and their feedback; s/he also need to attend professional committees. He also collaborates with his colleagues regarding Accreditation standards".

Hospital's Training Officer holds that:

"This role is [defined] in the domain of professors, specialists, teachers, coworkers and medical students. This sector tries to design educational plans based on educational needs. Generally, his/her role is to present relevant training to apply Accreditation programs".

An important point about provided responses is different interpretations of the interviewees regarding their role in Quality Management System. Another significant issue is having belief in issue of quality improvement. As stated earlier, Quality Management System could be successful when everybody believes in improvement of quality.

6.4.3. Private Hospital in Tehran Case Study C (TCPRV)

The majority of interviewees had the same idea regarding the role that they have in Quality Management System. As Accreditation is ordered by governmental organizations (Ministry of Health and Medical Education) in formal forms, the staff are obliged to

implement it. They are the executives, coordinators and supervisors in Quality Management System. Thus, due to presence of such a pyramidal structure (in which the decisions and programs are ordered by top management and are applied by the bottom of the pyramid) there is not much space for people to have more active roles. The Quality Improvement Department manager said that:

> *"After being admitted by the hospital, the plans made by the Ministry of Science and Medical Education are ordered to different sectors of the hospital. Then we try to implement them based on the timetable that is given to us. And in most of them we are the plan performers".*

The Nursing Department Manager added that,

> *"They are the performers and mediators among Nursing Department and Quality Development Office and organize Accreditation plans in Quality Management System".*

The hospital Manager's attitude is quite different from the coherent perspective of the staff regarding Quality Management system. They maintain a critical perspective towards Quality Management System in relation to their role and said that the integrated system, which is in progress, limits peoples' role to do the plans that are ordered by the ministry. The Nursing Department Manager continued:

> *"Presently, all the personnel and authorities are engaged in Accreditation system. This hospital has just been opened. In addition, it is the first thing that hospital management team implements and follows in Strategic planning.*

Accordingly, special training were considered for the staff of the hospital. On the other hand, the hospital itself tried to apply some measures independent from Health Ministry decrees. However, due to insufficient knowledge, instability of the policies, traditional management, and trial and error methods in use, these plans weren't successful".

Unfortunately, the managerial sector of the hospital (which were mostly medical professionals) didn't have relevant knowledge of management. Although the responsibilities in the medical domain and managing methods were interconnected based on the Accreditation system (JCI), learning some professional terms were necessary. Before Accreditation system (JCI), EFQM was conducted that obtained good progress and all its potentials were actualized. However, in spite of its success, there was some resistance against the model. In recent years, the Ministry of Health has obliged all hospitals to keep a general, standard, and systematic Accreditation system.

A key point in the provided responses is that individuals are limited in Accreditation system in terms of accountability. In other words, they felt that they were the mere performers in the present system. It can be said that prior to the time that Accreditation was ordered as an integrated system, they were more successful in its implementation.

6.4.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

The majority of interviewees' responses (as it was the case with the private sector in Kermanshah) stated that their roles in Quality Management System are as performers,

coordinators, supervisors and evaluators. Since hospitals are evaluated based on Accreditation achievement (implementation), their success in its implementation affects their budget and rating. On the other hand, with respect to private sector, they try to get harmonized with ordered plans by Health Ministry. The leader of the hospital said says:

> *"We perform as coordinators. Accreditation system has 37 aspects and we are responsible to apply and coordinate the plans that are performed by affiliate subsections or top management. Consequently, our performance is evaluated based on this criteria"*.

The manager of Quality Development Department asserts:

> *"As manager of hospital Accreditation sector, I am responsible for implementing the above-mentioned model of Quality Management System which is being ordered by Health Ministry"*.

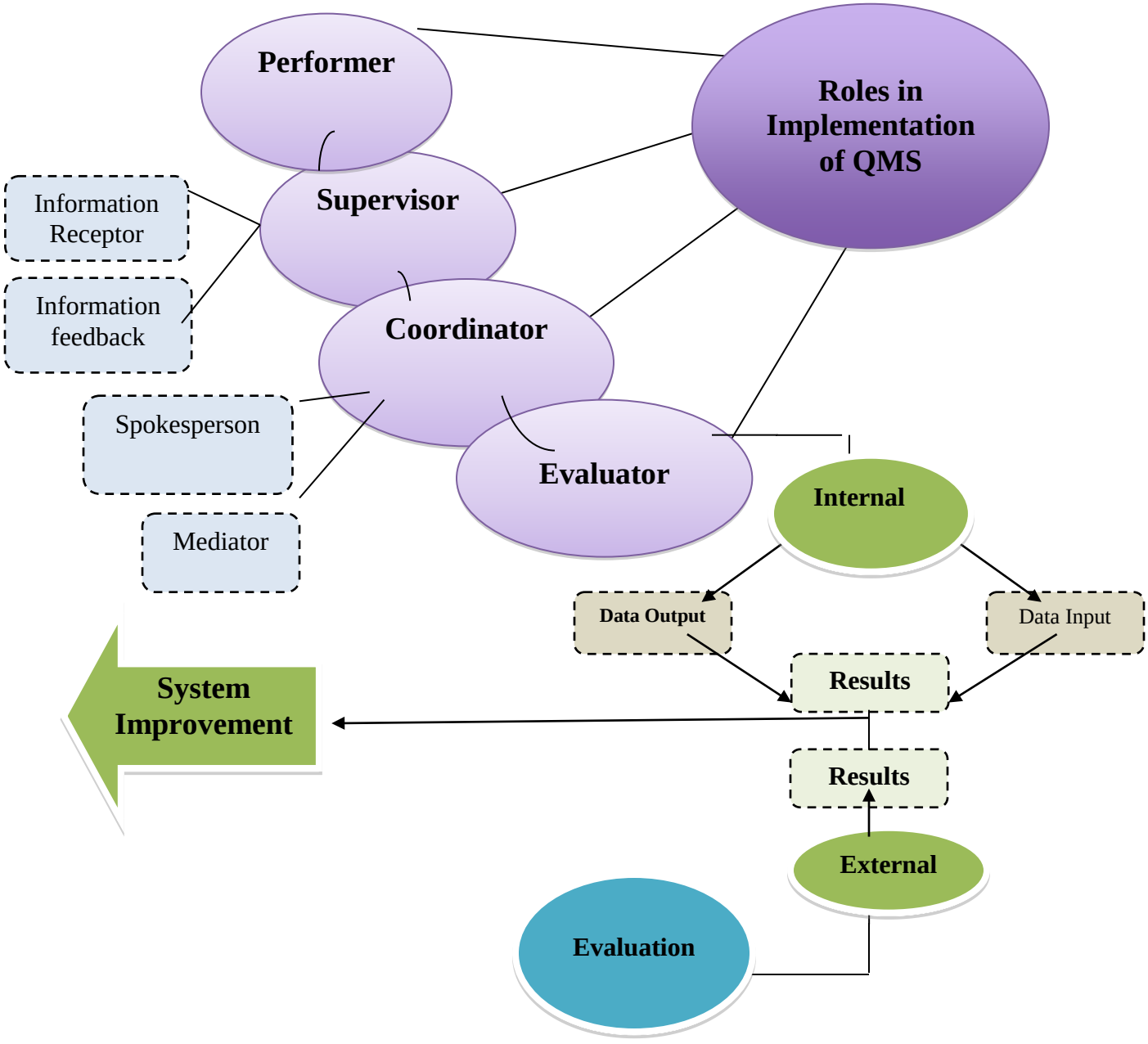
The head of hospital's technical sector added:

> *"Since, we are scored based on our role in private sector; we are the mere performers and surveyors in performing and evaluating the plan correctly"*.

An important point about the provided responses is that hospital and peoples' role in Quality Management System is limited in applying the plans. In such conditions, they are scored, funded and credited based on the extent to which they implement Accreditation system. Thus, if the hospital wants to use its present potentials along with Quality Management System, it faces barriers.

The diagram 6.4 describes the different roles of the interviewees and their interaction with each other regarding Quality Management System. It is seen that some people just formally implement Quality Management System and do not have an active role in the implementation of quality management; they are solely the performers of Quality Management System. It also shows that some people have supervisor, coordinator and evaluator roles in implementation of the quality management system.

Figure. 6.4: The Role of People in Quality Management System



6.5. The Organization/s, which Decides about Choosing the Type of Quality Management System

The most important similarity found among the provided responses is that all interviewees agree that the Health Ministry is the sole decision-maker in the present pyramidal structure. Decisions are made on the top level, and the orders are transformed to the lower level through connective channels. The second similarity observed in all hospitals was the focus on Accreditation system's deficiencies and the fact that Quality Management System (Accreditation System) needs development. Another common issue that was found in the provided responses was that all sectors should have a role in decision making based on Quality Management System plan and should be able to comment and present some ideas according to their roles and responsibilities.

A significant difference was private sector's focus on the effort to apply some changes not only in the presented Quality Management System by the Health of Ministry but also in its authorial frameworks in order to apply a more localized (customized) and harmonized system based on the conditions of customers.

6.5.1. Public Hospital in Tehran Case Study A (TCPUB)

All provided answers in public hospital said that Health Ministry and Medical Education decide at highest level. Consequently, what follows is an official hierarchy down to the lowest levels. The leader of hospital maintained:

"Health Ministry is the sole decision maker and the hospital doesn't play any role in decision-making. Health Ministry is the main decision maker and we are obliged to follow and apply the decisions. We should implement their decrees since the hospital financing is based on the Health Ministry's rating and it is dependent upon the extent to which Accreditation standards are kept".

The manager Quality Improvement Office said that

"Before 2009, the Hospital Manager made decisions, but since 2009 and later on the Health Ministry makes all the decisions and we are all under control and supervision of medical university".

A significant point about provided answers is the criticism that was implicit in the responses. For instance, the head of the hospital said that in the Health Ministry there is no obvious criterion for decision making and determining the style of Quality Management System. In addition, they implied that all the decisions and plans were planned primarily based on trial and error and lacked scientific basis. Moreover, the scopes of the plans are limited, and they are patterned without localization (customizing). Consequently, the desired competence and efficiency cannot be observed.

6.5.2. Public Hospital in Kermanshah Case Study B (KCPUB)

In response to the question "which organization makes decisions regarding Quality Management System", all said that the Health Ministry is the main decision maker. In such a pyramidal structure, the decisions are made on the top level, and through connective channels the orders are transformed to the low level of pyramid. Although some respondents said that decisions are sometimes made in hospital, they have no effect or role in Quality Management System and are mainly operative decisions. The leader of hospital concurs that:

> *"Health Ministry and Medical Universities decree the decisions and the hospitals are obliged to apply them. Health Ministry is the main decision maker; their decisions and plans are mandatory. Prior to the implementation of Accreditation system they were not mandatory, but now their decisions and plans are fixed and we only apply them".*

The Quality Development Manager said:

> *"Unfortunately, all decisions are made in the Health Ministry; the decision makers aren't Kermanshah natives. In the past, the hospitals made decisions in the context of EFQM. The decisions were made to choose the kind of management system and we obtained positive outcomes.* Now the *decisions are made in Health Ministry based on Iran's' 20-year prospect plan. The Health Ministry orders all its plans to hospital management and its subsections".*

An important point in the provided answers is interviewee's dissatisfaction with the present decision-making structure in the system. The hospitals made better decisions before 2009, and they had better performance because they used all their knowledge capacities, potentials and, human resources.

6.5.3. Private Hospital in Tehran Case Study C (TCPRV)

In a similar way, in their responses, all the interviewees in the public sector maintained that the main decision maker is the Health Ministry. They maintained that it is in the highest level of the pyramid, making decisions from the highest level to the lowest level through their own mechanisms. The leader of hospital stated that:

> *"Health Ministry is the main decision maker and its supplementary wings are medical universities. The medical universities are responsible to apply hygiene and health in the domain they control. All decisions are transformed to hospitals through bulletins and all hospitals (whether public or private,) are obliged to implement them".*

The hospital manager of Quality Development holds:

> *"Health Ministry is the main decision-maker, and we are able to decide at what time the system requires validation. But since Accreditation System is an ideal management system and we can't perform all presented conditions, they aren't all performable. Consequently, we apply some changes and perform them based on our needs and conditions. All Iranian hospitals are obliged to apply the decisions made about Quality Management System".*

A significant point about the provided answers is the private sector's effort to apply changes in Quality Management System plans presented by the Health Ministry. They attempt to apply more localized (customized) changes in order to harmonize the system along with conditions of customers and themselves.

6.5.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

The responses in private sectors refer to the Health Ministry as the main decision maker in Quality Management System. However, because of Iran's hierarchical governmental structure, private hospitals need to localize (customize) the quality management system. Thus, some items need to be added and some are required to be dispensed with. Consequently, it will be inevitable for these hospitals to make modifications in their ordered plan. The leader of hospital says that:

> *"Health Ministry and its subunits are the main decision -makers regarding Quality Management System. If any change in the system is required, they are ordered to medical universities by the ministry of internal affairs in form of special plans. Consequently, the plans are ordered to hospitals by the medical universities and we cannot implement any subjective form of Quality Management System".*

The manager of nursing department says,

> *All plans are ordered to Hospital Manager by the Vice Presidency of Medical Treatment and we are obliged to observe them. The General Assembly acts under*

the control of Health Ministry. And since the private hospitals have their own requirements some aspects should be added or removed from the decreed plans.

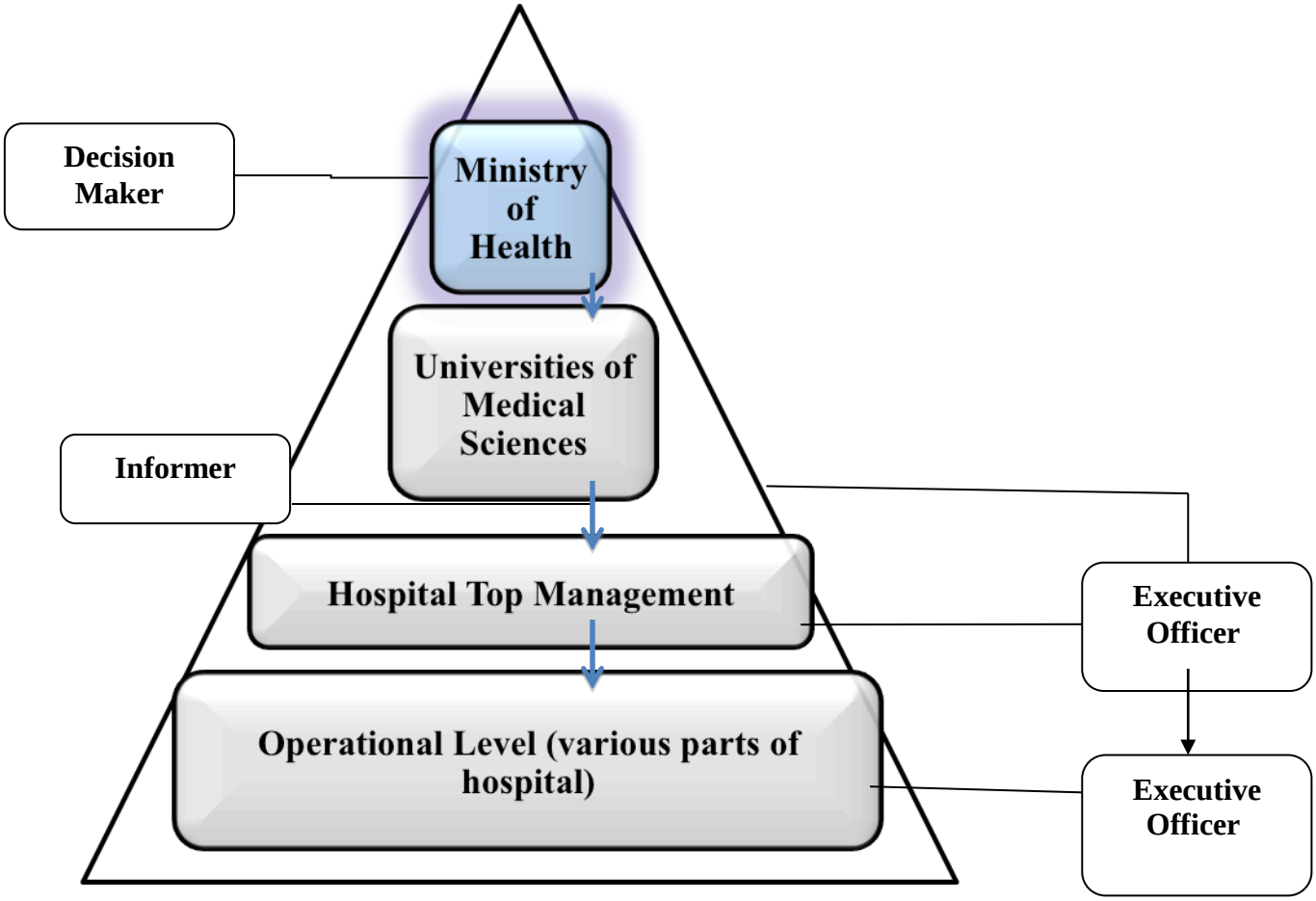
The Quality Development manager says that

"Because we work on Accreditation System, we are under its control. All the plans are ordered to the hospital by the vice presidency of the medical treatment and plans are imposed on hospitals directly. Unfortunately, because top managers are always changed, there are different attitudes and point of views regarding Quality Management System. But paying attention to hospital conditions, kinds of customers, hospital structural and physical positions in the management system are indispensable conditions in getting positive performance".

One of the significant points learnt from the answers to the questions is that managerial positions are unstable. Such an instability prevents following and applying the predetermined plans correctly; it also prevents their successful designation and presentation.

Figure 6.5 (pyramid) describes the hierarchy of decision-making in choosing the Quality Management System, which is its outcome. The figure indicates that the Health Ministry is the dominant decision-maker in the present pyramidal structure. Decisions are made on the top level, and the orders are transformed to the lower level through connective channels.

Figure 6.5: The Process of Choosing Quality Management System In Iranian Hospitals



6.6. The Limitations in Effective and Optimal Implementation of Quality Management System

The most important similarity in private and public sectors was the interviewee consensus about spontaneous effect of resistance to change on the one hand, and cultural factors that limit the effectiveness of Quality Management System. Interestingly, there was also a similarity in the centralized organization of the public sectors. In these sectors, decisions were made on the highest-level management pyramid with no authority being shared with the lower sectors. Another similarity was that all respondents emphasized the economic dimension, expenditures, cultural issues, and human working force, which to them theses factors put, the most limitations on the implementation of the decisions.

A significant difference between public and private sectors was the private sector's emphasis on individual aspects and organizational issues regarding the limitations in the implementation of Quality Management System. Another significant difference between public and private sector was that in Kermanshah's private sector the emphasis was on social, political conditions and lack of manager's support. The stark difference between Kermanshah and Tehran private sector was the Kermanshah's emphasis on scheduling dimension of the process of the implementation of Quality Management System. Another difference, observed in the both public and private sectors in Kermanshah, was special emphasis on education and training. They stated that personnel's knowledge about the implementation of Quality Management System is less than enough and can lead to big limitations.

6.6.1. Public Hospital in Tehran Case Study A (TCPUB)

Based on the responses, one can say that interviewees considered several factors as barriers to implementation of quality management system. The dominant ideas were individual beliefs, cultural issues and resistance to change. They regarded the economic fields and financial dimensions as the second level of the limitations. Regarding the official structure and the centralized system of public hospitals, it can be maintained that the above-mentioned limitations could limit the scope of Quality Management System. According to the leader of the hospital,

> *"Inflexible cultural attitudes and false beliefs among personnel in organizational structure is the most important limitation in the implementation of Quality Management System. Some other significant issues are the resistance to change, and financial problems. For example when we need money to achieve a plan in Accreditation system, financial problems and delays in funding appears to be unsurpassable limiting factors".*

Regarding this issue, the Quality Improvement Manager claimed that:

> *Human factors are the biggest limitation towards the implementation of Quality Management System in hospitals. Unfortunately the presence of disagreements, cultural issues, economic factors and low levels of education among staffs regarding the current systems of quality management create big limitations.*

A key point in the responses is financial problems and hospital's current expenses, which create big barriers in effective and suitable implementation of Quality Management System.

6.6.2. Public Hospital in Kermanshah Case Study B (KCPUB)

Financial problems, inflexible structures, centralized systems; organizational atmosphere, manager's resistance to change and personnel conservatism are some limitations in achieving effective and suitable implementation of Quality Management System. The leader of the hospital said that:

> *"Financial problems, inflexible structures, and atmosphere are among influential factors in this regard".*

The manager of Quality Improvement Office also adds that

> *"Conservatism and lack of mutual trust create limitations. In addition, budgeting and financial problems can limit Quality Management System".*

He continues that

> *"Economic factors and cultural issues create most limitations; on the other hand, resistance to change and the insufficient training of the staffs regarding Quality Management System can be limiting".*

Hospital's Education Executive Officer says that

> *"Although we have tried hard and continuously to convey suitable education and to maximize personnel knowledge, insufficient education, lack of awareness, organizational inflexibility, strict atmosphere and centralized system have created some problems"*.

A key point in the provided answers is the gap between personnel's required education regarding Quality Management System and the present level of personnel's proficiency. Another key points are lack of mutual relationship between Department of Management and other sectors, and resistance to change that can limit the effectiveness of Quality Management System.

6.6.3. Private Hospital in Tehran Case Study C (TCPRV)

Like the public sector, in private hospitals different factors and limitations such as social and political issues, resistance to change, cultural and economic factors are taken into account. These factors decrease the effective implementation of Quality Management System. Some other factors involved were lack of support in the implantation of the obtained results from the implementation of Quality Management System, lack of persuasion, and positive feedback by the management. The leader of the hospital maintained that:

> *"There are executive rules, limitations such as economic factors cultural factors and red tapes to implement every plan, while the quality management system isn't*

exceptional from this point, but seemingly what imposes the most limitation is the economic condition and we are experiencing it".

The Quality Improvement Office Manager says that

"We implemented the Accreditation system and were obliged to perform and presented it to the higher managers. However,, the managers didn't give their full support which disappointed the staffs and limited the progression of the plan. Besides, the key factor is lack of employee's motivation to implement quality management. But in my idea, all factors can be effective in the hospital Quality Management System and they should be taken into account.

The Nursing Department Manager Emphasizes that:

"Restrictive rules impose these limitations. Unfortunately, being mandatory by the Ministry of Science, rules and regulations don't change accordingly…the most important limiting factors are the dominant culture, organizational structure, economic situations, and budget shortage".

A significant point in the responses is personnel's motivation and mood and their lack of enthusiasm to implement and promote Quality Management System. This is due to lack of support from top managers and inexact timetables for their services. However, the interviewee's points of views about limiting factors of Quality Management System were pervasive.

6.6.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

Similar to the public sector, the private sector considered four barriers to implement quality management, including: political, cultural and economic factors as well as resistance to change. Although it can be said that the emphasis was more on economy than any other factor. In addition to the above-mentioned factors, they emphasized on human factor because capable human force is the driving force of any organization's implementation of policies.

The leader of the hospital states that:

> *"You can't absolutely state which factors are effective since there are numerous factors involved. Besides, you can't name all, but what is tangible is the economic and financial factors because in their shortage, they can be very limiting. Cultural and social factors are also effective. Generally speaking, we should consider all factors"*.

The Quality improvement office Manager argues that:

> *"Human force is the most effective limitation, then timing schedule and finally the expenses"*.

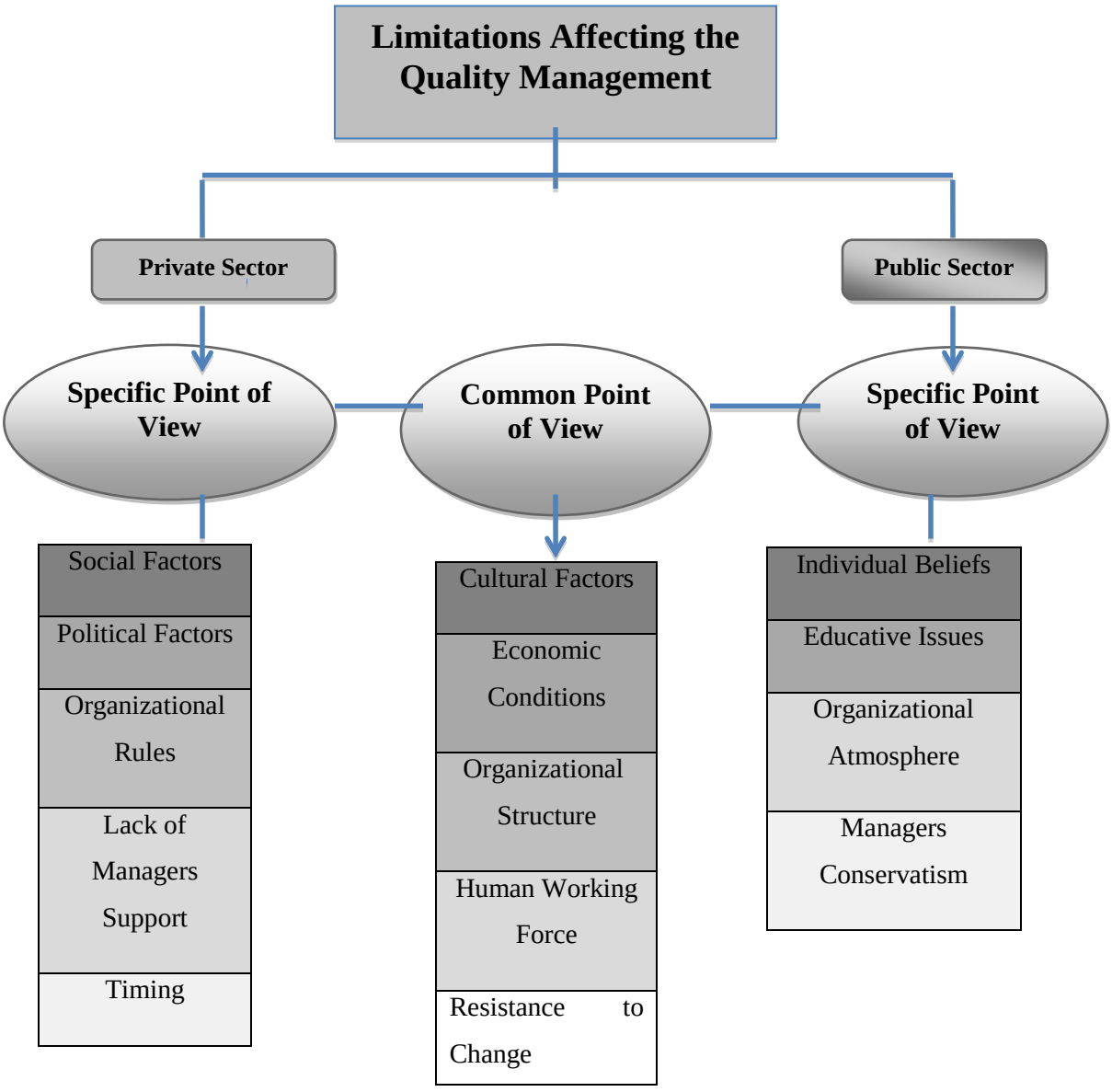
The manager of nursing department said that

> *"Lack of adequate and scheduled evaluation regarding the decreed plans by Health Ministry on the one hand, and staffs that have little knowledge about Quality Management System validation on the other hand create significant part of the limitations. You can't expect to have a good performance unless you solve all these problems"*.

The important point in the implementation of Quality Management System strategy is paying attention to the concept of time. Due to quick changes in Quality Management System strategy in the medical services, ignoring the importance of time is a basic problem. As stated before, during a decade, eight styles of Quality Management Systems have been used both in the private and public sectors. If there were a preplanned time for every project, naturally we could yield better (or more effective) results and fewer changes in the Quality Management System.

Figure 6.6 indicates factors affecting the implementation of Quality Management System in private and public hospitals. It shows that there are some specific limitations regarding implementation of quality management in private hospital such as social factors, political factors and lack of manager's supports and etc. In addition, there are some specific points of view in public such as organizational structure and individuals belief.

Figure 6.6: Limitations in Effective Implementation of Quality Management



6.7. Staffs' Comments or Ideas Regarding the Implementation of Quality Management System

A similarity observed in all sectors was the *"Office of Suggestions and Comments"*, which received all ideas, and comments. Another similarity between Kermanshah and Tehran private sectors was dissatisfaction towards Accreditation in Quality Management System that was rooted in the inflexibility to receive and implement new ideas. Another similarity between Kermanshah and Tehran public sectors was lack of follow up and offering suitable feedback regarding staff comments. Finally, in both sectors, the staffs were apathetic and were reluctant to comment about Quality Management System.

A significant difference between public and private sectors was the significant discrepancy regarding the extent to which they notice the staffs' comments. In public sector, there was lack of follow up and implementation of the comments. On the contrary, the private sector cared more about the comments of the staff and the clients.

6.7.1. Public Hospital in Tehran Case Study A (TCPUB)

The provided responses are at times paradoxical and conflicting. Some senior managers, specially the Head of the hospital, pointed to staffs' disinterest and lack of enthusiasm in Quality Management System. In contrast, some others stated that low-ranking staff are active in this case and hospital management has special support in this regard. One can say that this gap between ideas originates from lack of effective relationship between different departments.

The Hospital Manager states that:

> *"Our personnel don't participate a lot in our system, especially low-ranking staffs whose engagement is not practical. However, the middle ranks of our organization are more active in this regard. If they give us really good ideas, it is certainly accepted. The hospital has the committee of opinions and we'll give special reinforcement to the best ideas"*.

The hospital's Affairs Executive Officer states that

> *"New ideas are usually offered. We have a system of surveying which is related to the committee of administrative reforms. Having gotten ideas from the staffs, we give cash or other prizes to the best comments"*.

The Quality Improvement Office manager says that

> *"Managers resist new ideas because they are already inundated by numerous problems in the current trends"*.

The Patient's Safety Expert maintains that

> *"We have some committees, which include fixed and observatory members. We invite middle level managers to comment. Their comments will be analyzed. If we find them helpful, we accept the ideas specifically if they are acceptable…everyone, having a comment can send us in a written form. The managers welcome this issue very warmly"*.

A key point about responses is lack of special organizational support for the offered ideas. On the other hand, staff are so busy with the issues related to their job that they don’t have enough time and spirit about Quality Management System. It can be finally maintained that while Accreditation in Quality Management System implements some measures (metrics), because it is dictated by outside inflexible forces (such as Ministry Of Science), there are limitation for its successful implementation.

6.7.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The answers in Kermanshah state hospitals refer to Opinion Committee that receives staff’s ideas regarding hospital affairs. After receiving the comments, this committee analyzes the suggestions. If accepted, they are implemented in the related sectors. Such a specialized committee can be an effective factor along with staffs' effort in processing different ideas. However, it is necessary to evaluate these committee’s activities to find out whether it is successful in reaching its stated goals or not. The leader of the hospital says that:

> *“We have a strategy to participate and review the Quality Improvement Program. One of our items is to engage the staff in the process of decision-making. We have a committee to get employee's ideas and to investigate their opinions. If it will be accepted, our office will reflect it to the hospital and Medical Science University”.*

The Quality Improvement Office manager states that:

> *“We have a special subject in the Management Science that persuades all the staffs to notify the mangers about the existent problems and shortcomings. To*

make sure, we will encourage them, investigate the situation and will make a feedbacks regarding to the hospital and its different sectors. Unfortunately, the suggestions that we receive are few and limited."

The Quality Improvement Executive Officer says that:

"We have a committee; named Opinion Committee that has announced that for each suggestion (even rejected ones) they offer a prize. It was done to persuade personnel, but unfortunately it wasn't received extensively".

A key point in the answers is the Opinion Committee's lack of continuous participation regarding the employee's comments and the reluctance to follow-up the cases. As revealed by one of the interviewees, in a year they didn't have any meeting. One can say that when staffs' opinion is in conflict with managers' disinterest and reluctance, little incentive remains to offer new suggestions.

6.7.3. Private Hospital in Tehran Case Study C (TCPRV)

The answers in Tehran private hospitals refer to an open and supportive system that welcomes its staffs' different opinions and suggestions regarding different issue. It can be said that because the private sector has an inclusive look on the competition, it considers all dimensions including staff's different ideas in different situations. The Hospital Manager states that,

"The hospital and its managers have always wanted to persuade employees to give their ideas, and hospital management sector welcomes them warmly. We

have an Opinion and Criticism Office in the hospital that receives the staff's comments and persuaded them to do so more often. Even it dedicates some prizes to persuade active and ever-participation of the workers".

The Quality Improvement Office Manager said that,

"In the middle and higher ranking positions the related authorities are active about giving ideas and suggestions regarding the hospital and its patients".

A key point in the interviewee's opinions was an open and supportive system in the private system in receiving staff's idea. In addition, it was accompanied with a positive and good reaction from organizations and the staff. Consequently staffs offer their ideas to their organizations. An open and supportive system can reinforce the relationship between staff and management. In addition, since the staffs are more engaged in the current issues, they can convey suitable and beneficial ideas to the management.

6.7.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

The provided responses in Kermanshah private hospitals refer to the staffs' attempt to comment about hospital issues and hospital's support of the presented ideas. However, what is important is that the offered ideas aren't included in the Quality Management System framework, which is due to inflexible structure of Quality Management System implementation in the hospitals. This inflexibility is the result of validation system ordered by the Ministry of Science in a preplanned format, which can't be changed or reformed. The Head of the hospital says that,

"There is a specific sector in hospitals called Suggestion and Complaints Office. It persuades the staff to comment about hospital issues, and there are some cash and other prizes for the comments. Naturally, the staff will comment, and we have had good examples in this regard. However, it is not in the format of Quality Management System, as it is ordered by the Health Ministry and we are obliged to follow it completely".

The Quality Improvement Office Manager says that

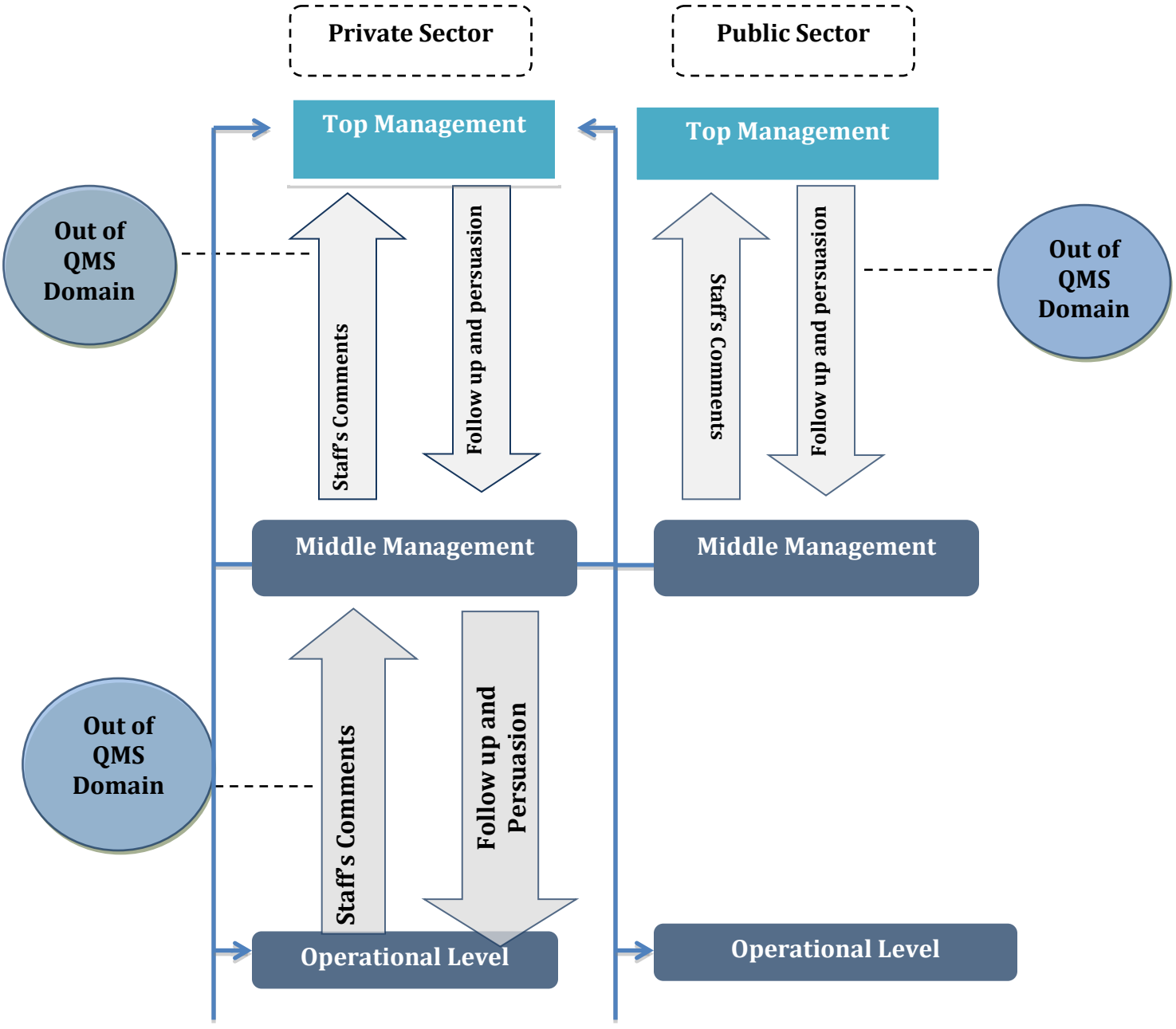
"Because different sectors of the hospital and vice presidencies have direct contact with the management, they comment about different issues. But low-ranking sectors just convey their ideas to their chief manager. The management department has assigned weekly meeting for direct and mutual presentation of opinions for all the personnel. There is a Suggestion and Comment Office in the hospitals and all personnel give their comments in written or verbal forms, and if accepted, they will win some prizes".

A key point in the interviewees' remarks was that staff's opinions weren't compatible with those of Quality Management System. As mentioned earlier, the Accreditation system doesn't accept changes, new goals or ideas in its plans, and the hospitals are obliged to implement it carefully and completely without any change.

Figure 6.7 describes the feedback in the private and public sectors. It is seen that there is a significant discrepancy regarding the extent of feedback (staff's comments) in public

and private hospitals. In the public sector, there was lack of follow up and implementation of the comments between middle management and operational levels. On the contrary, it shows that the private sector cared more about the comments of the staff and the clients.

Figure 6.7: Staffs' Comments and Feedback



6.8. Most Effective External and Internal Factors Regarding the Implementation of Quality Management

A similarity observed in all sectors was the emphasis on the influence of international sanctions as one of the main external effective factors. The significant similarity in the public sector was the emphasis on the influence of Health Ministry and Medical University as influential external factors on hospitals' plans and activities (such as Quality Management). Interestingly, there were similarities in the public sectors, which included the existence of the centralized organization in public hospitals that made decisions on the top of the management pyramid and were not willing to share their authorities with the lower sectors. Kermanshah's public sector was concerned about hospitals' lack of authority in its activities. In fact, the centralized structure made limitations and had negative effect on the implementation of the Quality Management.

A significant difference in the private sector was Tehran's private sector's emphasis on competitive aspect and the attempt to gain a competitive advantage in order to attract customers' attention, whereas in the Kermanshah's private sector, the emphasis was on culture and economic situations.

6.8.1. Public Hospital in Tehran Case Study A (TCPUB)

In this case, the provided answers refer to economic factors and sanctions as two basic elements. In this context, it can be mentioned that the economic dimension originates from the sanctions. One can say that medical organizations are easily affected by the

external environment especially regarding sources and information. This susceptibility can affect the hospital both positively and negatively in its processes and activities. The hospital's Improvement Office Manager in this regards said that:

> *"External factors are highly effective in the hospital. Primarily, Health Ministry and universities can affect state hospitals because they are controlled by them. In addition and in a broader perspective, the sanctions were very effective especially regarding the shortage of medicines. Generally speaking, effective factors include: sanctions, medicine shortage, equipment, financial problems and lack of human force. Another problem is that we can't hire the specialized workforce".*

The leader of the hospital added that

> *"QMS implementation is especially affected by economic factors, for instance financial problems delay staff's payments and make them disappointed. Eventually it affects the quality".*

A key point regarding the responses is hospital's reluctance to hire employees according to its requirements. Both Ministry of Health and medical universities do so without need assessment in the sources of different parts. Consequently, it affects implementation of Quality Management System. An important barrier on the way of progress in organizational tasks such as implementation of Quality Management System is the existence of the centralized organizations. They make decision on top of the management pyramid and don't give the required authorities to lower sectors.

6.8.2. Public Hospital in Kermanshah Case Study B (KCPUB)

Similar to responses in Tehran public sector, the responses in Kermanshah public hospital referred to several factors including: sanctions, economic factors, lack of equipment and so on. However, the hospital leader stated that health ministry and medical university are main factors. They have direct and external effects on hospital's activities such as the implementation of Quality Management System. The leader of the hospital highlighted that:

> *"There are several factors involved in this regard, but the medical university is the main agent influencing all activities and determining the hospital's guideline by its plans and offered instructions".*

The Quality Improvement Office Manager who was interviewed stated that:

> *"Several factors such as sanctions, economic factors, lack of equipment and medicine affect the hospitals and their specific activity regarding the implementation of quality management ".*

A key point about the responses is the direct effect of Health Ministry and Medical Universities on the overall activity of the hospitals. One can say that hospitals, especially in public sector receive their plans from the universities and are not able to make decisions about their affairs freely. However, it can be said that the Health Ministry and medical universities' effects on hospitals are always negative and the positive effects are rare.

6.8.3. Private Hospital in Tehran Case Study C (TCPRV)

The responses referred to different factors which include various domains. Private hospitals have less financial problems in comparison with public hospitals. On the other hand, the influential factors are the sanctions and lack of technological resources. Another factor is competition in private sector to offer better services to the customers that is a very effective factors in Quality Management System. The leader of the hospital said:

> *"There are direct and indirect influential factors, but sanctions, lack of sources and lack of technology are the most effective ones"*.

The Hospital Manager added that,

> *"Because we are the private sector, we try to attract more customers or patients. Naturally, the competition will be effective. In addition to the limitations, the sanctions are of high importance"*.

A key point in respondent's ideas is the special attention of private sector to competition. By focusing on its competitive advantage and by offering better services, it tries to attract more customers and to dominate a greater share of the market. Competition can create significant changes and encourage the organization to maximize the quality of it services and activities.

6.8.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

The responses in private hospitals referred to different factors including sanctions, economic conditions, lack of sources, technology and competition. But another factor that was not stated in other sectors was the fact that Kermanshah is not comparable to Tehran in terms of the accessibility of the advanced technological equipment. As a further clarification to this issue, it can be stated that in Iran, usually there is a great discrepancy in terms of access to modern equipment between Tehran on the one hand and other cities on the other. Consequently, being farther away from Tehran would signify less availability of much needed medical resources. Tehran's distance from Kermanshah has had its bad effects on the hospital's performance and services and has made detrimental effects in terms of technology, education, information sources and so on. The Head of the hospital in this regards said:

> *"We are in western part of Iran, and being far from the Capital has made detrimental effects on our performance. In a developing country such as Iran, the capital is much more developed compared with other cities, so educated people and professional people tend to move to the capital. Therefore, being far from the capital has affected us in terms of different training and information sources. For example in terms of education, we are less qualified compared to the hospitals in Tehran".*

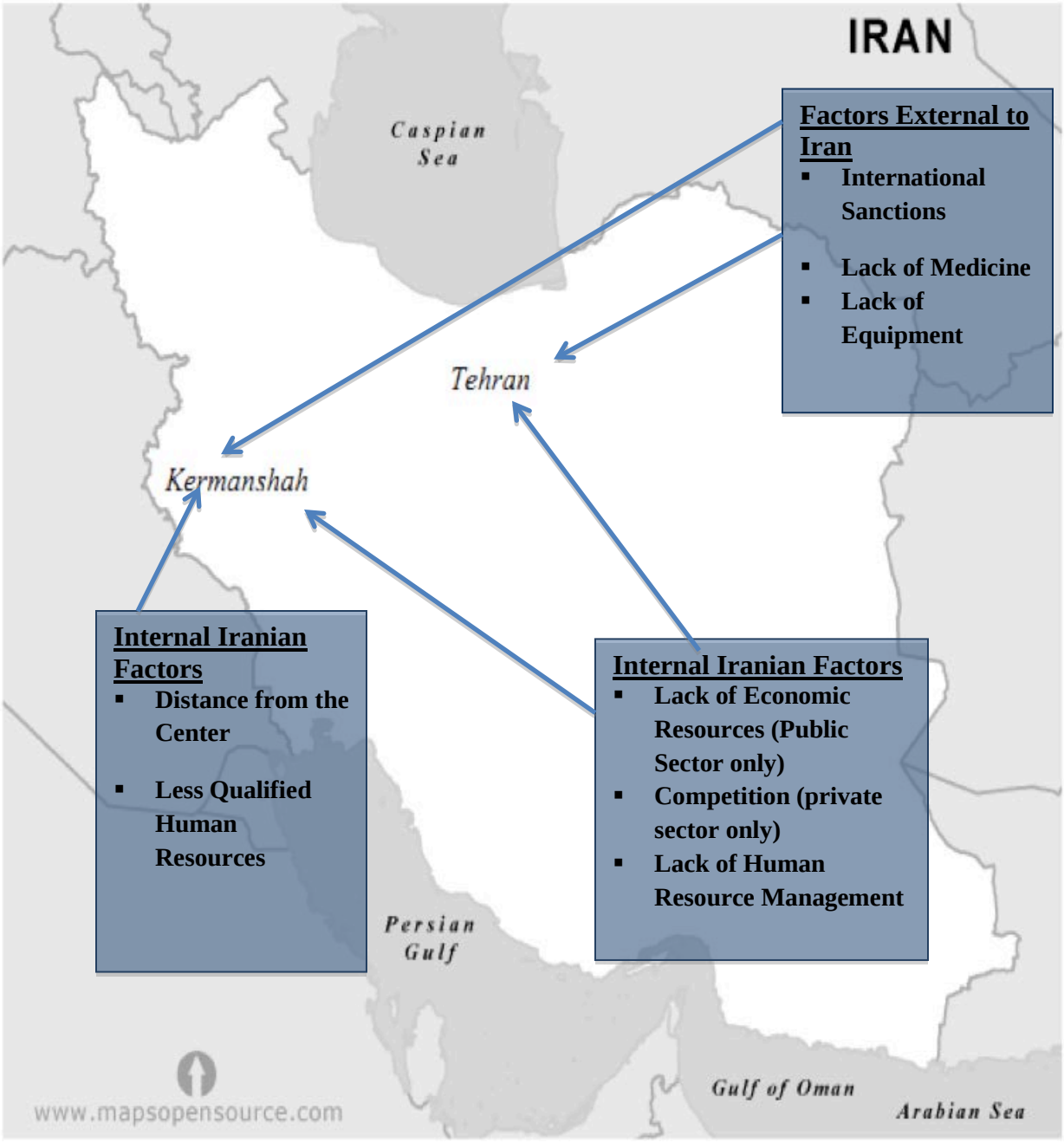
The Nursing Department Manager also said:

"A number of factors influence the hospital directly such as sanctions, economic conditions and specifically customer's financial situation. When common people don't have enough money, they rarely go to private clinics and hospitals. I believe that sanctions are the most influential factor in hospitals regarding medicines and especially in the case of special diseases. Regarding technology, we have lack of sources because of sanctions".

A key point in respondent's ideas is the gap in terms of equipment between Tehran and other cities. As mentioned above, it created many problems regarding information sources, the level of training, and access to financial sources and so on.

Figure 6.8 describes the effective external factors in implementation of Quality management system. It is seen that factors affecting the implementation of quality management system in Iranian hospitals are divided into internal factors and external factors and also divided into Kermanshah and Tehran cities.

Figure 6.8: External and Internal Factors Affecting the Implementation of Quality Management



6.9. The Hospital Directors' Leadership

Most interviewees defined leadership in terms of the skill to motivate a group of people in order to achieve organizational objectives. Regarding the given questions, the significant similarity was the incongruity of the answers in terms of responsibilities and roles. Again, just like the definition of the concept of quality, there was no comprehensive definition regarding the definition of hospital leadership. Some interviewees agreed that the chairman of hospital needs to be a leader, and they also referred to other roles and duties. Some interview in private hospital defined leadership as a leader should also reach the organizational goals by managing the staff that is his/her subordinates. They also believe that leadership is significantly different from management in terms of their functions. Based on such a perspective, leadership is regarded as decision-making and ability to communication with member of organizations, where as management is regarded as coordinator and supervision. However, some interviewees defined leadership as someone tries to affect a person or a group of people; it is also defined as the skill of communicating with a group of people. Consequently, it can be said that leadership is superior to management.

The difference in public hospitals of Tehran and Kermanshah can be stated in terms of the first one's emphasis on the role the Head of the hospital as a leader; for the latter, the emphasis was on managerial aspects. The significant difference between the private and

the public sector was based on the public sector's limited perspective regarding the duties of the Head of the hospital in comparison with private sector.

6.9.1. Public Hospital in Tehran Case Study A (TCPUB)

In this case, the provided answers maintain that hospital leadership is defined in terms of the development in the implementation of organizational activities and plans through management of subordinates (or the low-ranking staffs). In fact, they consider leadership as a sort of social dominance, in which the leader asks for staff's voluntary participation to achieve organizational goals. Leaders need to have optimum authority to encourage the (subordinate) staff's voluntary participation in the hospital affairs. Leadership is also defined as the skill of motivating a group of people to achieve organizational objectives. The Head of the hospital said that

> *"At first a leader should be a good coordinator, since in our system the relation among the Ministry of Health, Medical University and lower departments is highly important. If the staff trusts the leader, s/he can perform the affairs better and more effectively. In addition, leadership is defined as a process whereby an individual influences a group of people to achieve organizational objectives"*.

The Quality Improvement Office Manager maintained that,

> *"Prior to being a boss, s/he should be a leader and interact with the employees. The Leadership and the management in a system should be in a mutual interrelationship. It can be said that the extent to which the leadership affects the*

performance of the hospital is closely connected to the success of the manager in reaching his/her goals".

6.9.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The responses refer to managerial definition of hospital leadership, which is based on current issues and the role as coordinator. One can say that coordination is a complex form of human and structural mechanism to facilitate achieving the desired goals. In this regard, the Head of the hospital said that:

"The Head of the Hospital coordinates the current and future. Because the hospital is a big organization, the Head of the hospital does his affairs through his assistants. However, the issues that are related to medical care is done by the manager and current issue and problems are conveyed to the Head of the hospital by the assistants, and finally s/he is the final problem solver".

The Quality Improvement Office Manager defined hospital leadership as follows:

"It is defined in terms of implementing the tasks by others. A leader should be a good coordinator on the highest level of the organization to teach others how to act. As a good coordinator, s/he should effectively benefit from other people's capabilities. A chairman is a decision-maker and a coordinator between different sectors and needs the ability to solve the problems".

A key point regarding the responses is limited to the definition of hospital's leader role in terms of being the coordinator and motivator. In academic definitions, different

factors are included among which one can name coordination. For example, Mintezberg refers to interpersonal, informatory and decision making roles. In addition, each one of these roles is divided to sub-roles.

6.9.3. Private Hospital in Tehran Case Study C (TCPRV)

The answers in Tehran private sector put stronger emphasis on the managerial roles. They stressed on the implementation of hospital's plans and approaches. In fact, the main feature of the presented definitions is the redefinition of organizational plans and goals. In this regard, the Head of the hospital maintains that:

> *"Not only the Head of the hospital has the managerial role, but s/he is also a leader. In other words, not only he has to advance organization's plans and activities, he also has to be effective in terms of communication with the staffs and needs to be able to recognizing their needs. Furthermore, the Head of the hospital is the chief manager in hospital and monitors all the affairs"*.

And the Nursing Department Manager stated that:

> *"The Head of the hospital has the most important role in organizational pyramid. The Head of the hospital is responsible to gain the predetermined organizational goals in the determined time. Thus s/he needs to perform different roles. The Head of the Hospital (the chairman) enforces the general policies of hospital and is in direct contact with the Ministry of Health and Medical Education"*.

A key implicit point in respondents' answers is that the Head of the hospital pays less attention to leadership responsibilities. In other words, the features of leadership are rarely seen on the organizational level.

6.9.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

In their responses for presenting a definition for the role of the Head of the hospital, the interviewees primarily stated that the chairman of a hospital is a leader and then they referred to other roles and duties. A key point in the answers was interviewees' emphasis on leadership.

In this regard, the Head of the hospital believes:

> *"Primarily, the chairman of the hospital is a leader and then a manager. He should be able to advance the organization's plans and affairs by means of inherent personality features such as: intelligence, knowledge, social interaction, and so on"*.

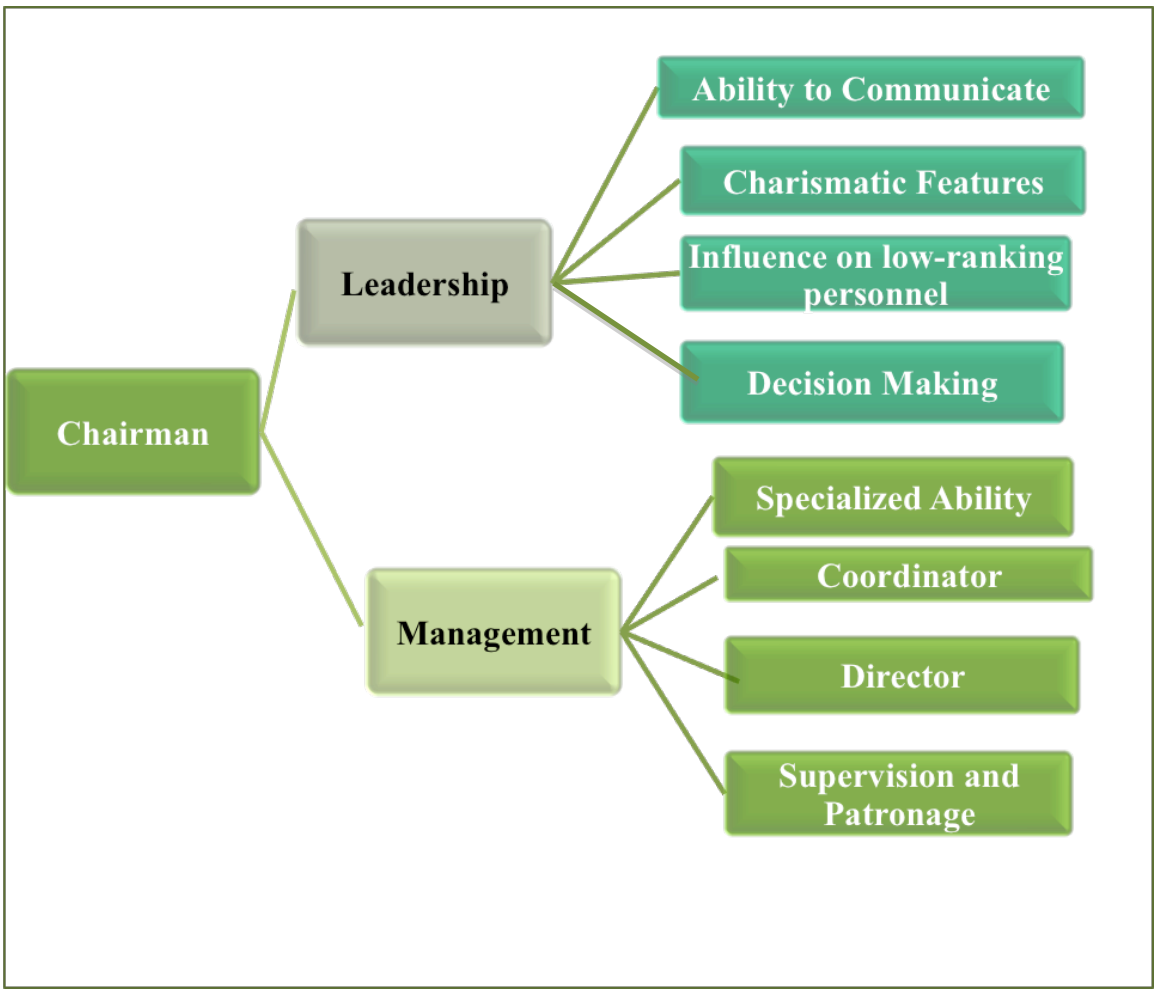
The Nursing Department Manager added that:

> *"There are different definitions in terms of the leadership of the hospital. Hospital chairman is a leader characterized by the coordinative abilities on the one hand, and decision making and communication skills on the other hand"*.

Figure 6.9 describes the role of Head of hospital (chairman), dividing it into two dimensions, which include leadership and management. The figure indicates that that the head of the Hospital has two complementary roles of leadership and management;

leadership by having charismatic characteristics and ability to influence and establish effective communication with subordinates trying to advance organizational goals; management by having special ability and coordination and directing they try supervision and patron ship in accordance with organizational goals.

Figure 6.9: The Role of the Head of the Hospital (Chairman)



6.10. Management Patterns in Hospitals

The most important similarity in private and public sectors was the interviewee consensuses that many Iranian hospitals have been applying classic and traditional management (mechanistic) structures; however, recently, there have been new developments in the implication of Participative Management Pattern. A similarity observed in the private hospitals is benefitting Participative Management System as the main management patterns in hospitals in the line of implementing Quality Management System. In the private sector, the management attempts to use an organic managerial model, which corresponds to the hospitals needs and requirements. A similarity in public sectors was a hierarchy-centralized structure, in which the final decision-maker is the top management.

Moreover, in spite of benefiting from participative management, the public sector tends toward classic and traditional management, while the private sector tends towards organic and open systems.

6.10.1. Public Hospital in Tehran Case Study A (TCPUB)

The given answers in public hospitals of Tehran to a great extent refer to development in the implementation of Participative Management Pattern. It can be said that since the all respondents have official posts, in their responses they maintained that they implement Participative Management. However, while referring the classic and traditional management structure, they implicitly pointed out to the inability of the

hospital in the implementation the modern Quality Management System. The Nursing Department Manager concurs that:

> *"In medical system we haven't been able to apply the Modern Management (Pattern). In fact, many Iranian organizations have been applying classic and traditional management structures but recently, there have been new developments in the implication of Participative Management Pattern".*

The manager of Medical Documents Admission who was interviewed added:

> *"Regarding the present limitations, you can't say whether it is completely traditional or modern, but what is tangible is the progressive implementation of Participative Management Pattern".*

A key point in the context of the provided responses is the inflexibility of management structure in its capability to implement the modern systems of management. Therefore, in Iranian public hospitals, with their centralized medical system and an inflexible official hierarchy in which everything is dictated to by the Health Ministry, it is impossible to apply the contingency pattern based on Quality Management System.

6.10.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The responses in Tehran public hospitals refer to progress Participative Management Pattern. It is worth noting that because of personnel's high level of education (that mostly are PhDs), there is a rich reservoir of human capital to contribute in resolving the current issues. Therefore, due to centralized and inflexible structure of hospitals (specially the

public ones), Participative Management as a common pattern can be taken advantage of as a strategic approach. The Quality Improvement Office Manager stated:

> *"It seems that the Participative Pattern is in progress. However, the top management has an upper hand. For example, all ideas maybe presented in a meeting, but the final decision is made by the top management"*.

The Quality Improvement Executive Officer pointed out that:

> *"Fortunately, we no longer act based on traditional management. The Head of the hospital hears his staff's ideas eagerly, and finally makes decision based on the received information and data"*.

Here, a key point is the issue that although it seems the Participative Management is in progress, the top management of the hospital makes the final decision. In fact, there is no distribution of authority from the upper levels to subordinates levels.

6.10.3. Private Hospital in Tehran Case Study C (TCPRV)

Similar to the previous sectors, the interviewees stated that the private sector implements Participative Management System as the main management pattern; however, in the context of Participative Management System, the private sector uses all human sources efficiently because it has no other main goal than attaining competitive advantage. The Head of the hospital stated that:

"Here, no decision is made individually. We apply an organic management. Before taking any action, we consider the ideas. We have different councils to reach the logical decision. In addition, through the Participative Management the hospital leadership uses personnel's scientific and technical capabilities".

The manager of Medical Documents Admission added that

"We implement scientific management. Consequently, the management considers all personnel's insights and engages the personnel in decisions that are made for the hospital .The head of the hospital makes the decisions through holding sessions with different sectors".

A key point regarding the provided responses is the interviewees' complete negligence regarding managerial issues and theories. This deficit can be due to the reason that personnels' jobs do not correspond with their educational backgrounds. For instance, the Quality Improvement Office Manager defines scientific management wrongly and goes against the scientific definition of the issue. Taylor, as the pioneer in scientific management, believes in a traditional and inflexible structure, in which the managers and the staff are stimulated by the economic factors.

6.10.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

The responses in Kermanshah private hospitals referred to an organic and open system and specifically introduced Participative Management. Since every organization is trying to go ahead and be successful, it has to extend the decision making to the lowest

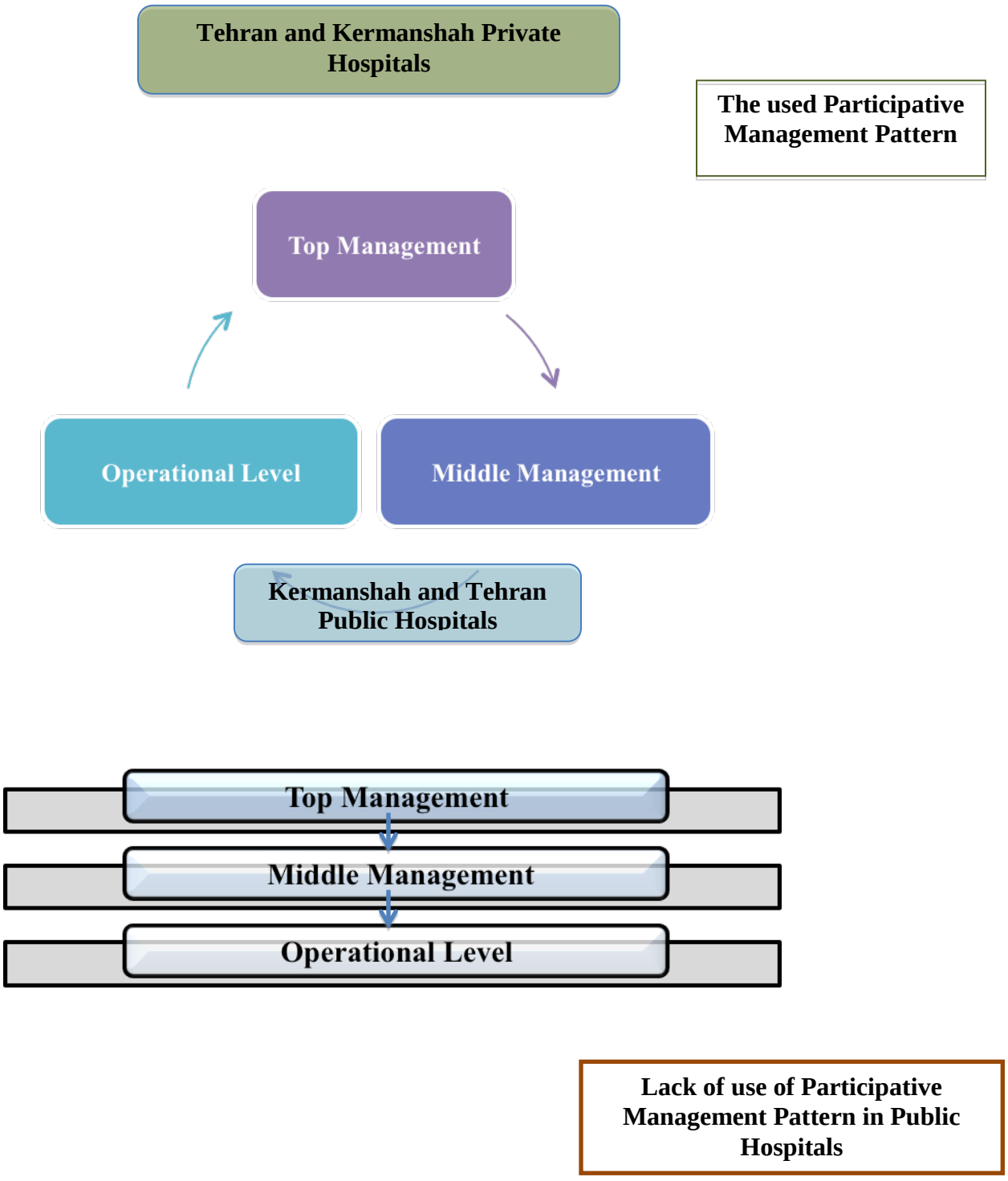
operational level. Moreover, in this level, personnel are more familiar with the organizational problems and issues and can offer their ideas effectively. The Nursing Department Manager said that:

> *"The management tries to present an open managerial system but if we are obliged to introduce a special pattern, it is undoubtedly Participative Management"*.

An implicit key point regarding the provided responses is the private sector's freedom of action regarding the managerial pattern. Consequently, the managerial pattern in private sector, which is directed through a board of directors, is carried out based on an opened system format.

Figure 6.10. distinguishes a participative and hierarchical management patterns in private and public sectors. The figure shows that there is an ongoing pattern of participation in decision-making between top, middle management and operational level in private hospital in both cities Kermanshah and Tehran. However, it also indicates that there is lack of use of participative management patterns in public in both cities Kermanshah and Tehran.

Figure 6.10: Organizational Patterns Used in the Hospitals



- **Summarizing Patterns of Leadership in Use**

Private	**Participative**
Public	**Authoritarian**

- **Summarizing Patterns of Leadership in Use**

Kermanshah	**Participative or Authoritarian**
Tehran	**Participative or Authoritarian**

These tables 6.1 and 6.2 indicate the patterns of leadership, which are in use in private, public sectors in Kermanshah and Tehran. Based on the findings, the pattern of leadership in private sectors was participative pattern; whereas, public sectors was authoritarian in which the final decision-maker is the top management. Furthermore, the patterns of leadership in use in Kermanshah and Tehran were Participative or Authoritarian.

- **Summarizing Patterns of Organizations**

Kermanshah	**Mechanistic**
Tehran	**Somewhat Organic**

This table 6.3 shows the patterns of organizational structure in Kermanshah and Tehran. The pattern of organizations in use in Kermanshah is mechanistic structure; whereas Tehran is somewhat organic structure.

6.11. More Important Roles in Quality Management System

Most respondents agreed that the Head of the Hospital has an essential supportive, cooperative, and strategic role in the implementation of Quality Management System. When the Head of the hospital believes in the implementation of Quality Management System, it leads to the improvement in the performance of the organization. However, some interviewees believed that every categories such as management, physicians and stuffs, have a distinct role in the implementation of Quality Management System. Based on this view, all the elements get together like a puzzle and will ultimately improve the quality of the presented services.

A similarity, which was observed in all sectors, was the attention paid to factors within the organization regarding the successful or unsuccessful implementation of Quality Management System. A similarity in the public sector was managers' belief regarding the implementation of Quality Management System. A similarity in the private sector was the emphasis on the fact that all parts of the organization should contribute in the implementation of Quality Management System.

Another similarity, which was observed in Tehran private sector and Kermanshah's private sector, the top managers play a significant role in implementation of quality management system. Quality Management System is a comprehensive process that can be practiced successfully. Quality management is not an issue that can be

institutionalized alone or by one sector. Consequently, there is a need for public cooperation in this field.

Regarding the effective implementation Quality Management System, a difference that was observed in Tehran's private sector, was a top to bottom perspective. However, in Kermanshah's private sector, it was from bottom to top. A difference observed in Tehran public sector was the special emphasis on the role of directors. However, in Kermanshah, in addition to the emphasis on the role of director, other executive roles were also emphasized.

6.11.1. Public Hospital in Tehran Case Study A (TCPUB)

The responses referred to various areas. In spite of the trivial differences between comments, interviewees mostly said that the Hospital President has basic and strategic role in the implementation of Quality Management System. If the Head of the hospital believes that Quality Management System can develop the organization performance, undoubtedly, it will lead to desired administrative effects. In this regard, the head of the Hospital said:

> *"Like other organizations, we have customers. However, our customers are patients who have special needs. Thus, we are obliged to provide a service that is of quality. But since we have had a traditional system so far, the management of the hospital has more important roles in the implementation of Quality Management System".*

In this regard, the Hospital manager added:

> *"When the top management believes that the Quality Management improves the organizational performance and tries to achieve it, the staff will work more efficiently. In this context, the Head of the hospital has a supportive role."*

In this regard, Quality Improvement Office Manager claimed that:

> *"As the most powerful person in terms of authority, the head of the hospital is a very important figure. When s/he wants to do something regarding the improvement of the quality of hospital, it can convince all the personnel about the Execute Quality Management System".*

The key point noted in the provided responses is the issue that the hierarchical traditional management can be a serious obstacle in line with the quality management system, because some factors postpone implementing the quality management system such as: lack of communication and interaction in the organization, and comprehensive, free, and fast transmission of information and the experiences of the different units.

6.11.2 Public Hospital in Kermanshah Case Study B (KCPUB)

The responses refer to the role of the executive figures in Quality Management System. All are equal qualitatively, but there are quantitative differences. In other words, while all are involved in the process of Quality Management System, the level of their

contribution is different. It can be said that different opinions are raised in this regard. One the one hand, some consider the role of physician, and on the other hand, others consider the role of Administrator as the key individual in the implementation of Quality Management System. The expert in Patient Safety in this regard maintained that:

> *"Seemingly, all consider the leader (chairman) as the key person. Moreover, faith and belief in the development of the plans can have more important role"*.

In addition, Quality Improvement Office manager held that:

> *"Doctors play an important role. If the doctor believes in Quality Management System, s/he would ask the nurses to implement it"*.

The expert responsible for the evaluation of medical institutions added that:

> *"This issue depends on the efforts of all, but perhaps an effective role depends on the level of ability and education and some other factors"*.

The key point in the provided responses is the effective role of specialists and doctors in Quality Management System. Because based on their influence in the organization, they can convince their staff to give better services. This can be viewed as a recommendation for the administrators to take effective steps in the context of the Quality Management System.

6.11.3. Private Hospital in Tehran Case Study C (TCPRV)

Similar to the public sector, the answers provided in the private sector of Tehran refer to the key role of the Administrator in the implementation of Quality Management System. One can say that nowadays, with the spread and development of the Quality Management System, it can be firmly said that the role of Head of the hospital (director) is more important than other organizational posts. The Quality Improvement Office Manager claimed:

> *"The first line of the work is senior managers and director of the hospital. In the first place, they should believe in the implementation of Quality Management System' and then, the middle level managers and operational managers have the most important role. This system can be an effective solution to improve the quality of the services that the system offers to customers".*

The Emergency Department Manager said that:

> *"Management and the Broad of Directors (the General Assembly) play an effective role. The Head of the hospital plays a key role when the director tries to Improve Quality Management System and all follow him/her [sic]. However, it does not mean that other sectors do not have any roles. All are effective".*

A key point to point out believes in the implementation of Quality Management System by top management, which is a prerequisite for the successful implementation of Quality Management System. The director's willingness and belief in Quality Management System is of paramount importance in its successful implication. In

addition, this matter can also be significant in transmitting the motivation to the employees, so they put all their efforts to improve Quality Management System.

6.11.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

Similar to Tehran's private sector, in Kermanshah's private sector the top managers play a significant role. As mentioned previously, Quality Management System is a comprehensive process that can be practiced successfully. Quality management is not an issue that can be institutionalized alone or by one sector. Consequently, there is a need for public cooperation in this field. The hospital leader claimed:

> *"All are involved including the hospital top management to lowest-ranking personnel. Quality is all encompassing and all should put their best efforts in this field"*.

The Technical Manager of the hospital added:

> *"Senior managers have effective role in this regard. But in realistic terms, the staffs play the main role and senior managers are just supporting"*.

The implicit key point in the responses is every sector's specific and effective role in the implementation of Quality Management System.

Figure 6.11 describes the role of the staff in the implementation of the Quality Management System. The graph indicates that categories such as management, physicians and stuffs, have a distinct role in the implementation of Quality Management.

It is seen that the emphasis on the fact that all parts of the organization physicians, management and staffs such as nurses do contribute in the implementation of Quality Management.

Figure 6.11: Roles in Quality Management

6.12. The Barriers Facing the Chairman of Hospital in His/Her Attempt to Implement Quality Management System

The similarity observed in both private and public sector was the discrepancy in the managing methods of the chairman of the hospital. In the private sector, the emphasis was on the resolution of conflict and disagreement by senior managers. However, in the public sector, financial problems created obstacles for the Head of the hospital management to conduct his duties.

The significant difference between private and public sector was the conflict between the individual and organizational interests with private sector emphasizing on the senior management as source of conflict in the hospital, whereas in public sector the physicians were being emphasized. When individual interests are prioritized over organizational interests, a deep gap is created between the individual and the organization that finally endangers organizational unity. Consequently, this issue can delay fulfilling the organizational goals. The difference between Kermanshah and Tehran hospitals seen in the private sector Kermanshah was the emphasis on the facilities and structural space, which wasn't observed in the private sector of Tehran. Difference in the private sector was that in Tehran they emphasized on the physicians as conflict makers, while in Kermanshah the staff were the source of conflict.

6.12.1. Public Hospital in Tehran Case Study A (TCPUB)

The responses referred to various areas. They include culture, human force and related issues as a source of conflict. However, the disagreement between physicians and the owners of the hospital is very influential in the performance of the hospital. In other words, the manger/s of the hospital cannot oblige them to follow the regulations, and unfortunately, physicians act based on their own interests. In this regard, the Quality Improvement Office Manager said:

> *"Physicians are the main decision-makers. They are smart, intelligent, powerful, and hardly accept other ideas. Unfortunately, they follow the traditional methods and have made problems regarding the implementation of Quality Management System".*

The leader of the hospital claimed that:

> *"Wherever the Physicians feel that the policies of the hospital are in conflict with their interests, they start to resist against any changes. Eventually, they create conflicts and transgressions. The main point is that every change is faced with resistance, and finally this issue creates unresolvable conflicts".*

A key point to be considered in the provided answers is the conflict between the individual and organizational interests, which is especially noticeable in the case of physicians and members of Scientific Committee. When individual interests are prioritized over organizational interests, a deep gap is created between the individual and the organization that finally endangers organizational unity. Finally, this issue can postpone materializing the predetermined programs and organizational goals.

6.12.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The responses in Kermanshah public hospital point to the conflicts created by the operational staff, which include doctors, nurses and so on. Of course, other differences and conflicts are expressed like the behavior of the manager and financial problems. The tendency to focus on the staff from all aspects has been a sensitive topic in recent studies. These studies emphasized lack of loyalty and low commitment that not only do not go in line with achieving the objectives of the organization, but also create a sense of indifference toward problems of the organization. These issues ultimately weaken cooperation spirit among other colleagues and postpone or even prevent the success of the organization. In this regard, the Head of the hospital said that:

> *"The hospital is working in three domains: medical, educational' and research whose implementation eventually faces some conflicts. The Education Department Manager says that personnel usually create conflicts and contentions that are due to insufficient education and lack of awareness. In addition, financial problems are of high importance".*

In this regard, Quality Improvement Office Manager claimed that

> *"Regarding these contentions, there is a great deal of disagreement between personnel, high-ranking managers, and middle-ranking managers. In addition, personnel's lack of motivation and participation creates a great deal of conflict".*

A key point in this regard is the personnel motivation and attitude in the context of organizational activities. In this respect, charismatic behavior of the leader of the hospital can be very effective.

6.12.3. Private Hospital in Tehran Case Study C (TCPRV)

The answers in private sector emphasize the conflicts created by the senior management. Senior managers are shareholders in the hospital, and conflicts are usually made between them and chairman. It can be maintained that that private organizations in Iran require an integrated system that could provide them with complete freedom. One should say that private organizations in Iran need an integrated system accompanied with complete freedom to the managers so that the manager can take some steps in line with organizational plans and goals. The leader of the hospital said:

> *"It is widely accepted that any change is associated with resistance. In case of any change, the first thing that personnel consider is their share and income. In this regard, an effective approach to eliminate resistance is the transparency of the presented issue. It should also be clarified whether the change produces loss and benefit for the members of the organization"*.

The Emergency Technical Manager maintained that

> *"Conflicts are more concerned with organization's managerial pyramid.... this is due to the reason that the members of management committee have affective roles*

and interests. Consequently, there are always disagreements among senior managers regarding the management of the hospital".

An effective method to resolve resistance against change is to present reliable information regarding the goals of the new programs prior to their implementation. Accordingly, the personnel feel that they are recognized as valuable members for the organization. Consequently, they consider themselves responsible for the implementation of the programs in the organization.

6.12.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

The responses in Kermanshah's private sector pointed to existing structures and facilities. They also referred to organizational limitations that ultimately end up in the creation of conflicts. In addition, individual interests on the high levels of senior management were important points that the interviewees pointed to. The Quality Improvement Office Manager stated:

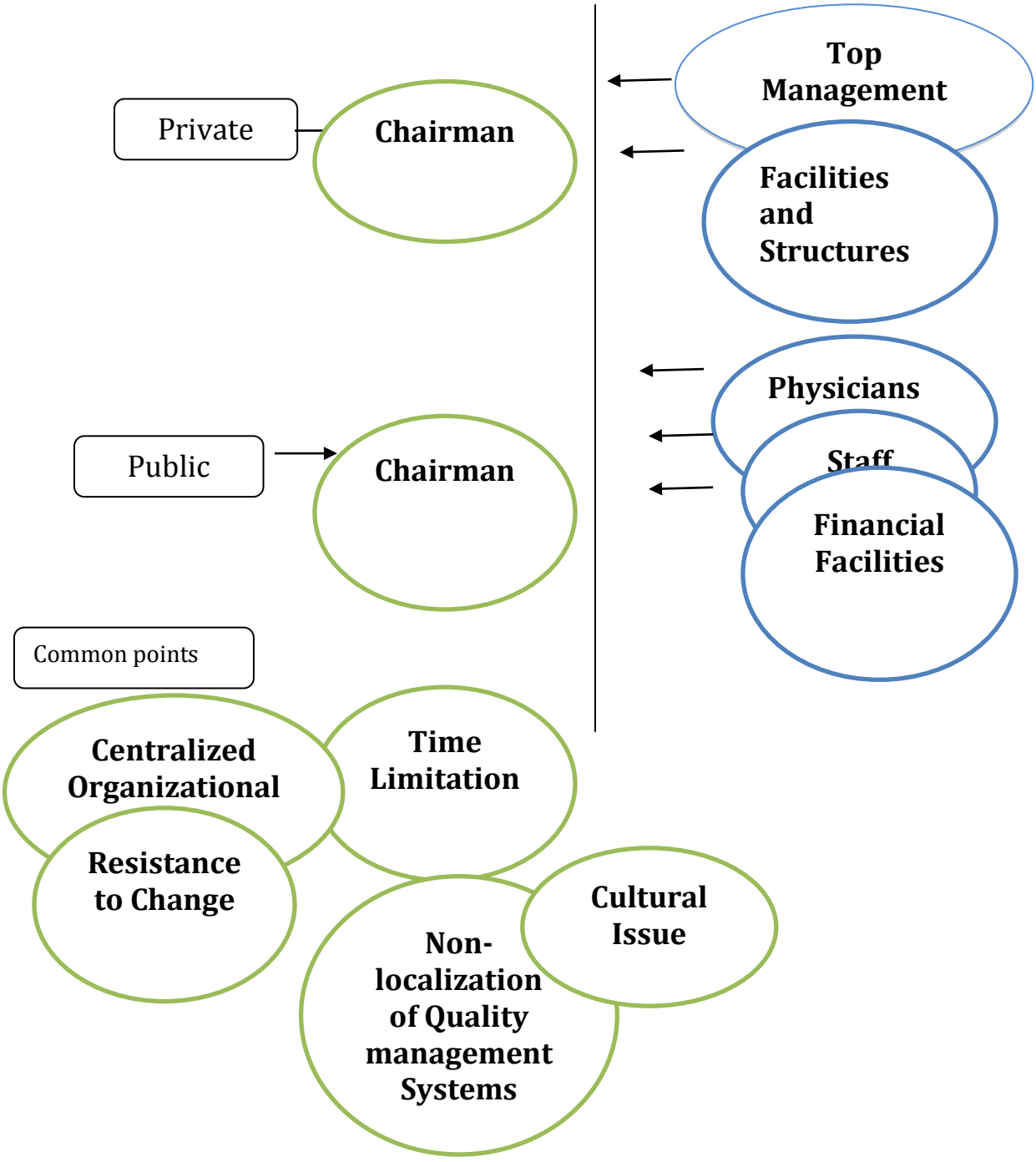
"The shareholders of the hospital that are also the members of Hospital Management Committee resist the programs or decisions they feel are in conflict with their interests. Moreover, facilities, financial and structural conditions can make problems".

The leader of the hospital mentioned that:

> *"Contrasts and differences can be observed in the hospital top management because there is an ongoing hidden war to obtain the lion's share of interests and power"*.

Figure 6.12 describes the conflicts and challenges that private and public sectors face in the process of implementation of Quality management. The figure shows some differences between the private sector and public sector as well as some commonalities. In private sector there was emphasis on the senior management and facilities and structure as source of conflict, whereas in public sector the physicians and financial and facilities were emphasized.

Figure 6.12: Challenges to Managing Quality



6.13. The Conflict between Specialists' Values and Management Strategies

A similarity in all sectors was the conflict between specialists' beliefs and management strategies. A solution that was attempted to be implemented in the private sector was to offer an interaction approach as an effective strategy to cope with this challenge.

The difference observed between private and public hospitals is the different approaches to reduce conflict between specialist values and the management. Furthermore, another difference observed in the private sector, was Kermanshah's private sector emphasis on the conflict of interests regarding physicians' beliefs and the strategies of the management. Most interviewees in Tehran private hospital emphasized that the private hospitals are directed through public management, which acts as an executive team. This executive body is controlled by shareholders, and conflicts are usually created between specialists on the one hand and general body of management on the other hand. Interestingly, the observed differences in the private sector were more significant in Kermanshah than Tehran. The difference observed between public and private sectors was that in public hospitals the physicians were usually against the policies of the management; whereas, in the private hospitals, they were part of the management.

6.13.1. Public Hospital in Tehran Case Study A (TCPUB)

A key point to be noted in the provide responses, is the solution offered by the manager of Nursing Department in order to reduce the conflicts. This solution introduces a continuous mutual relationship between Managing Board and the doctors. The interpersonal and mutual relationship between the Administration Board and the doctors paves the way for mutual cooperation. It ultimately creates a sense of trust and confidence that can be effective to solve the disputes between both groups. Consequently, the organization can be successful in the implementation of any process such as Quality Management System. The Chairman of the hospital stated that

> *"There are always differences, especially in a hospital with several deputies. Naturally, the conflicts between units are due to the difference in the goals of Vice-Presidents. The uncompromising beliefs prevalent among physicians and their unchangeable cultural attitudes have made a great deal of conflicts"*.

In this regard, the Nursing Department Manager maintained that:

> *"Everyone has his/her ideas and perspectives, as a result of which some disputes are made. The Important issue in this regard is to reduce disputes. Mutual relationship between those who are involved in the conflict leads to the reduction of the disputes. By doing so, the perspectives of the members will change, and consequently, less effort is put into attaining organizational goals"*.

In this respect, the Educational Supervisor added:

> *"There are some differences in some cases, for example the director wants doctors to have continual relationship with the patients. On the contrary, some doctors do not have a good relationship with the patients".*

The provided answers are based on the disputes between the values and goals of the physicians and Managing Board's strategies. It provides an insight into investigating the root of this dispute. Primarily, there are some uncompromising beliefs among physicians who are unwilling to change. Secondly, there is a conflict between different visions, and there is also a difference between the objectives of each group that eventually makes the causes of these conflicts clear and tangible.

6.13.2. Public Hospital in Kermanshah Case Study B (KCPUB)

Referring to fundamental differences, the answers in Kermanshah' public sector was rooted in the personal and group beliefs and goals. This was observed in senior managers' belief in the implementation of Quality Management System. While the Manager's Board attempted to institutionalize Quality Management System, it has not been institutionalized among the doctors. In this regard, the leader of the hospital said that:

> *"There are disputes. Each group's goals result in a dispute, and when each group seeks its own interest, dispute is the natural outcome".*

In this regard, the Nursing Department Manager stated that:

> *"The fundamental problem is that while the senior managers believe in improvement of quality, doctors don't share this perspective. Unfortunately, we have had this problem for a while, and this is one of the issues that we have set as one of our macro and micro objectives. In fact, doctor's perspective in this regard does not coordinate with the organizational plans".*

Bases on the responses, the key point to be addressed is the delay in the accession of long-term objectives of the hospital (macro-objectives), which is due to the split between doctors and senior executives. Metaphorically speaking, this perspective can be passed on like a virus and other staff in the hospital might share this perspective.

6.13.3. Private Hospital in Tehran Case Study C (TCPRV)

The answers provided in Tehran private sector refer to disparity between managerial values and the implemented strategies. It can be maintained that different factors underlie this issue. In the first place physicians as shareholders can be the root of contention. Another significant issue is the difference in perspective between the physicians and the Managerial Board. In line with this argument, the Chairman of the hospital stated that:

> *"Because doctors are shareholders in this hospital, they create disputes. However, non-shareholder doctors make less controversies and conflicts and follow the management objectives and strategies".*

The Quality Improvement Office Manager added:

> *"If we look into the administration of the hospital, the hospitals managed though a board of directors have presented a better performance. They hire more specialized people; in addition, they implement their rules more easily and have less conflict about the implementation of the law. However, the hospitals that are not run in this way and are under the control of shareholders face many problems. There are always conflicts between specialists and Managerial Board. For example, in the implementation of Quality System that was obligatory, the specialists were the ones who made the most resistance"*.

In this case, the Hospital Manager added:

> *"The conflict is between the specialists and managers. Doctors' perspective is one dimensional toward management issues, but managers have multidimensional perspective. But the only way to improve the system is to interact in order to gain mutual understanding"*.

Offering interaction and mutual understanding is a basic strategy for addressing the challenges between managers and doctors. Lack of mutual understanding can create wide gaps between individuals, and this is especially the case with Organizational issues. Interaction is not merely being considered and impressed by others, it is also a mutual effect based on time and place that can be effective in the Implementation of Quality Management.

6.13.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

Based on the abovementioned arguments, it can be said that the economic interests of the doctors and their fixed working procedures has created an atmosphere, which is prone to conflict. As a solution, creating an atmosphere of mutual understanding is an effective strategy. The Head of the hospital states that:

> *"Based to their expertise, doctors regard themselves as the owners of the hospital and it is not acceptable for them to be managed by a non-specialist with a lower education".*

The manager of the Nursing Department highlighted that:

> *"Doctors are not so much amenable in their interaction with the mangers. They are specialized in their field and believe that they can do well without the decrees of the managers. Times and again, this perspective creates conflicts".*

The key point to be addressed here is that the expertise of the doctors, as a crucial factor, creates a great deal of conflict in the organization's activities. Numerous recent studies have stressed that expertise is a necessary prerequisite of human resources. However, lack of socializing skills and not internalizing the fact that the employees should be amenable toward the managing body has made a fertile ground for conflicts, gaps, and contentions in the hospital. This issue has also rendered the implementation of Quality Management System difficult.

Figure 6.13, 6.14 are based on roots of conflict in physician's beliefs and management strategies in private and public hospitals. It is seen that the private hospitals offer an interactive approach as an effective strategy to cope with conflict between physician and management. Whereas in the public hospitals, there is no solution.

Figure 6.13: The Conflict between the Doctor's Beliefs and Values and Management Strategy in Private

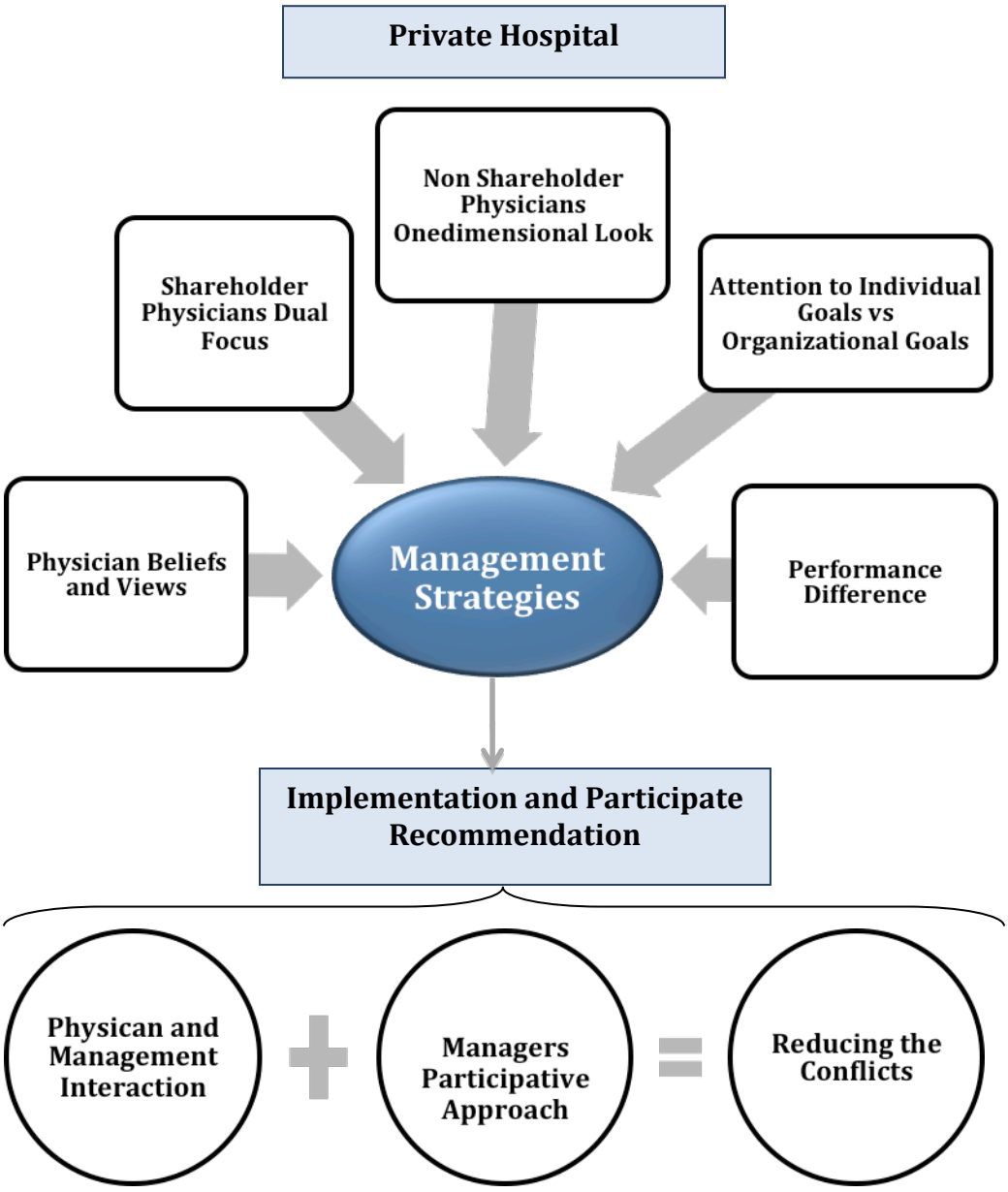
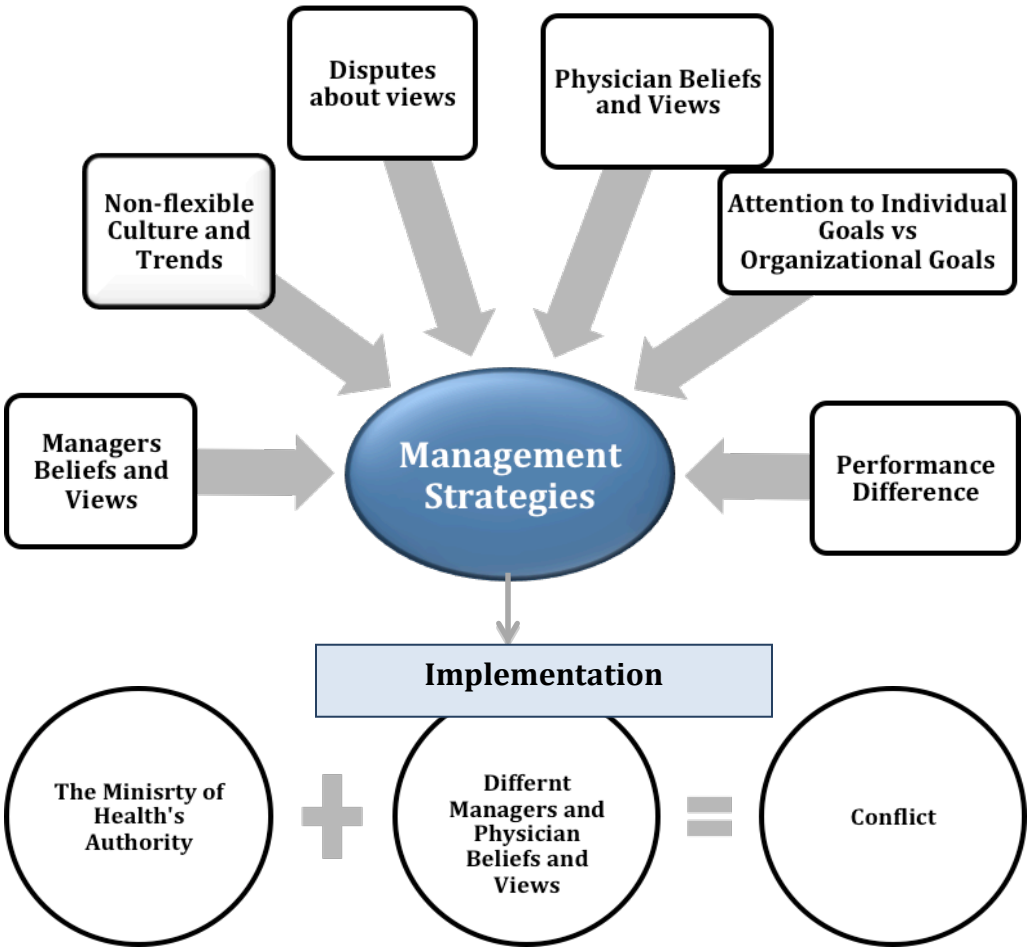


Figure 6.14: The Conflict between the Doctor's Beliefs and Values and Management Strategy in Public


Disputes about views
Physician Beliefs and Views
Non-flexible Culture and Trends
Attention to Individual Goals vs Organizational Goals
Managers Beliefs and Views
Management Strategies
Performance Difference
Implementation
The Minisrty of Health's Authority
Differnt Managers and Physician Beliefs and Views
Conflict

6.14. Interrelationships among Managers, Specialists and Governmental Departments

A similarity in the private sector between Kermanshah and Tehran was the emphasis on the role of management rather than the role of government and specialists, whereas in the public sector an equal emphasis is put on the role of the three groups, i.e. managers, specialists and government.

6.14.1. Public Hospital in Tehran Case Study A (TCPUB)

The answers provided in the public sector refer to an effective role of all three groups: the government, the board of management and physicians. It should be stated based on Quality Management System all of the three groups are effective, since all of them play a role in line with quality management system. Government has an effective role in policymaking, management, coordinating and executive roles; in addition, doctors are more affective regarding the issues associated with the patients. The Head of hospital said that:

> *"All three groups have an effective role. However, each group is more effective in one sector, for example, the managers is more effective in executing plans and the government in setting policies, regulations and investments. In the public hospitals, the government's role is more important; however, in the private hospitals, management sector has a more effective role".*

The expert in Patient Safety who was interviewed in this regard said:

"All three groups have important roles. Doctors are in contact with the patients; managers are coordinators and serve as a bridge with the outer organization, and finally the government has an important role especially in providing the budget".

The key point that can be noted in the responses is the issue that in public sector all the mentioned elements are effective, but in private sector the managerial sector gains more weight.

6.14.2. Public Hospital in Kermanshah Case Study B (KCPUB)

Presented responses in the public hospital of Kermanshah had special focus on the influence of the government, management and experts in the context of Quality Management System. Although the chairman's perspective and viewpoint was different, in interviewees' statements the main role is given to the government then experts and finally management. However, it can be argued that the government can play an important role regarding the policies of the hospital through its control over the allocation of the budget. In this regard the Head of the hospital said that:

"Depending on the attitude of the manager, the influence of another group differs. But it can be argued that internally the manager is more powerful and generally the government has the highest amount of authority".

The expert in Medical Institutions Evaluation in this regard stated that:

"I think the Government, Physicians and managers play the most important roles respectively".

6.14.3. Private Hospital in Tehran Case Study C (TCPRV)

While regarding all three groups as effective, the answers in Tehran' private sector stressed on the role of management. As a proxy and coordinator, the manager transfers the information to the governmental sectors. S/he also tries to act based on the interests of hospital by lobbying and trying to remove the conflicts and differences. In this regard, the Head of the hospital maintained that:

"We should execute all government's instructions. Specialist and management need to be obedient towards the government. All have effective roles, but the manager of the hospital has the most effective role".

The manager of the hospital claimed that:

"At first glance it seems that the government has the most important role, but with deeper analysis it seems that the managers have greater authority. Hospital management in such a pyramid has very effective role that even overshadows the experts".

In the tripartite model of the manger, the government, and physicians, the key issue to be pointed out is the special emphasis on manager's role. One can say that manager is the pivotal point of any organization and can be very effective in terms of coordination and integration. In addition to the organizational role, the manager serves as a buffer zone

between the hospital and other institutions that ultimately makes a good ground for interaction and mutual understanding.

6.14.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

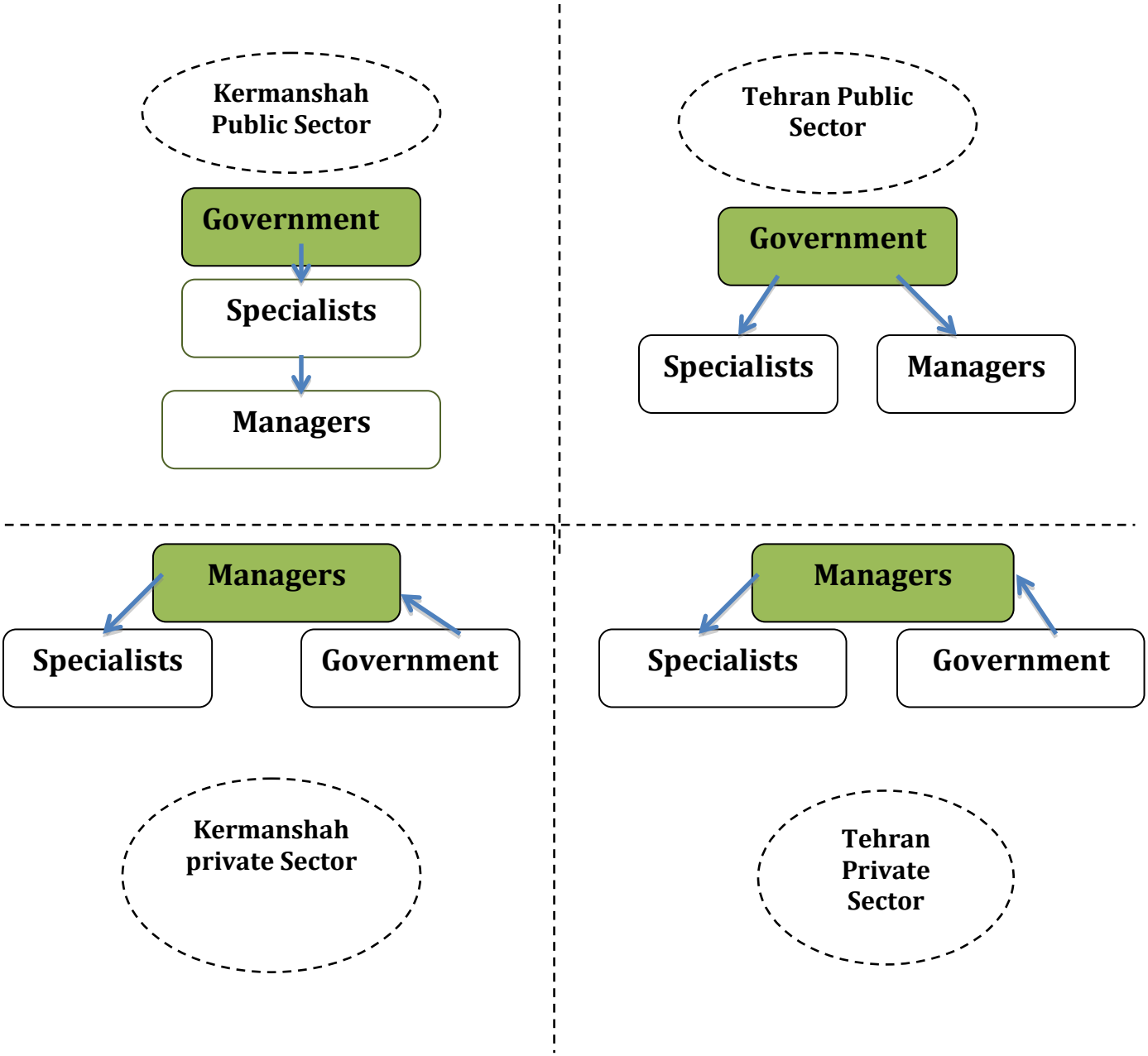
The provided answers referred to the effectiveness of all sectors of organizational triangle in the implementation of Quality Management System. However, there is a particular emphasis on the role of the manager. The head of hospital said that:

> *"You can't prefer one over the other and interaction between these three is necessary, and each plays an important role based on its duties. But I feel that the manager's role is more important and tangible"*.

The Key point that was implicitly referred to in the interviews was the strength of the private sector in its interaction with the government (which seems to be lacking regarding the public sector). In addition, in the tripartite model of the government, the physicians, and the mangers, there is a special focus on the role of the mangers in the private sector.

Figure 6.15 describes the relationship among the managers, specialists and governmental organization. It is seen that in private hospitals in Kermanshah and Tehran cities the emphasis was on the role of management rather than the role of government and specialists, whereas it indicates in the public sector an equal emphasis is put on the role of the three groups, i.e. managers, specialists and government.

Figure 6.15: The Relationship among the Managers, specialists and the Governmental organizations



6.15. The Effect of Culture on Implementation of Quality Management System

A similarity in private and public sector was the effect of cultural beliefs and attitudes on management and Quality Management System. A similarity between Tehran and Kermanshah's private sectors was needed to implement a customer-oriented method, which tends towards customer satisfaction. A similarity in public sector between Kermanshah and Tehran was the attention to culture in line with organizational affairs.

The difference that was observed in the private sector was the issue that the emphasis in the Kermanshah's private sector was in direction of organizational policies; however, in Tehran this emphasis was only directed towards the customers. In Tehran's private sector, cultural difference was observed in terms of its effectiveness, while in Kermanshah the negative aspects of the cultural difference were focused upon. The difference that was observed between the private and the public sector was that in the public sector, culture was focused on change and innovation while the private hospitals emphasis on culture was based on a customer- oriented perspective.

6.15.1. Public Hospital in Tehran Case Study A (TCPUB)

The answers also referred to importance of culture and its influence in hospital's activities in all dimensions. A significant point to be mentioned in this regard is that culture cannot be easily defined. Culture is a pattern of common assumptions that the group learns in order to solve problems of external and internal adaptability and coordination; it is also considered valid due to its positive effect on the performance of

the individual. Culture is taught to the members of the social group as correct perception. In this regard, the Head of the hospital said that:

> *"Lots of issues in the hospital are directly affected by our cultural presumptions. Culture is the basis of the activities of the hospitals, an instance of which is Physician's dominance in public (governmental) hospitals. If the cultural issues are not dynamic, there won't be any progress. On the other hand, if a culture has innovation and accepts changes, Quality Management System can be achieved easily. In addition, any change that is done in the system of management should be preceded by a change in the culture. In fact, changes in system are changes in culture. Culture in Iran is having a significant impact and which is due to governmental system".*

The Key point in the provided answers is the issue that culture is introduced as a prerequisite for change. In other words, when the cultural context is available, change comes about easily (an instance of which can be the implementation of Quality Management System). Otherwise, organizations will face barriers, and cultural problems create obstacles for the organizational changes.

6.15.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The answers focused on culture as a prerequisite in the implementation of Quality Management System. Organizational culture is a dynamic phenomenon. Based on such a dynamism, there is always an interaction between the environment and people. Culture is enriched due to external adjustment and internal integration, and can play an important

role when it is combined with other factors. In this regard, the Manager of Education stated that

> *"Culture is an index for the success of an organization. In an open and supportive organizational, cultural innovation is accepted, but in a closed culture we face stagnancy. Culture can be very effective in the presentation of services, for example, in recent years people's awareness regarding treatment has changed"*.

The Quality Improvement Office Manager explained that:

> *"Cultural issues are the main problem in our system. Sometimes culture is so uncompromising that it does not allow any further changes. If we have a localize perspective towards cultural issue, many problems will be solved. Culture is very effective, an instance of which can be the effective communication of medical staff and the patients"*.

An important point here is the attention of the Head of the hospital to the importance of a supportive and open culture. One can say in a culture where there is more emphasis on the regular organizational strategies and goals, the personnel are encouraged to take higher risks and obtain new resources of innovation. Some characteristics of such a cultural environment include a supportive and friendly working atmosphere, sincerity, trust, encouragement, and constructive participation.

6.15.3. Private Hospital in Tehran Case Study C (TCPRV)

Similar to the public sector, the answers presented in private sector focused on the effectiveness of culture in the context of hospital management. Culture is an effective generative tool and is a key prerequisite for growth in organizational life. In addition, culture affects the thinking methods regarding common issues among the staff, and can be a vital dimension in the satisfaction of the customers. In this regard, the Manager of Education stated that:

> *"Culture is effective, and we cannot ignore it. The dominant culture in an organization is rooted in all aspects of management. Hospital top management is trying to enhance a true and effective culture in all sectors. Culture is the most effective factor. For example if the cultural beliefs of the customer are not respected in the hospital, there will be a lot of problems in attracting the clients".*

The expert in patient safety believed that:

> *"Culture is very effective. When we are implementing an interactive project (such as Quality Management System), we are bound to have interaction with customers, specialists and other human resources. It should be stated that for the successful implementation of projects such as Quality Management System, we face different cultural perspectives. These different cultural backgrounds may create different feedbacks that consume the energy, time and financial resources of hospital".*

A key point in the responses is the emphasis on customer's satisfaction. The private sector needs more patients and investment. Thus, in order to reach its goals and based on its utilitarianism nature, it is required to have a customer-oriented approach towards culture.

6.15.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

While focusing on the importance of culture, the answers maintained that culture is to be formed through family, society and the organizations. Regarding the importance of culture, the observers believed that if it is supposed to create lasting and effective changes in an organization, the cultural aspect should receive a special attention. The Head of the hospital maintained that:

> *"The issue of culture is of high importance in the society. Culture is formed internally and externally. Since the hospital is located in the west of country, ethnic culture is very influential".*

The Quality Improvement Office Manager added that:

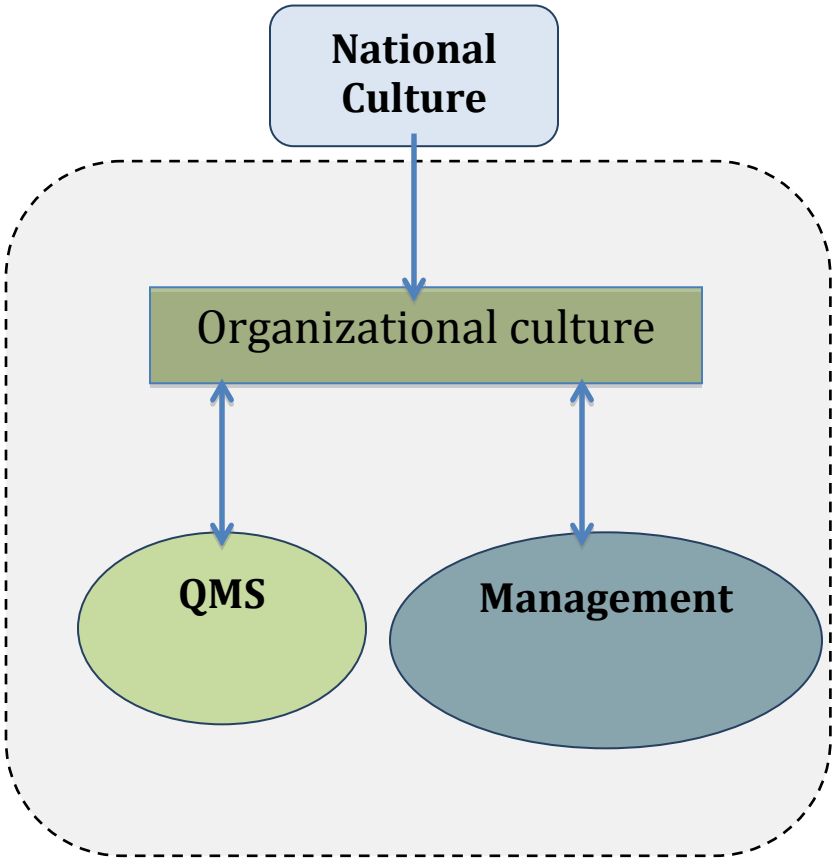
> *"Culture is certainly an influential factor. It is an indispensable part of every society and organization. It is cultural issues that advance the organization affairs. Regarding the customers, culture has the highest effectiveness. It is also affective regarding the hospitals and the patients".*

An important point to be noted here is the effectiveness of ethnic culture regarding the implementation of any system of management. In fact, tribal culture can play both a

positive and negative roles, for example, negligence towards sanitary issues is one of the problems in the tribal cultures.

Figure 6.16 describes the influence of both national and organizational culture on the management system. The figure shows the importance of culture and its influence in hospital's activities on all dimensions including quality management.

Figure 6.14: The Influence of Culture



6.16. Manager's Effective Performance in the Context of Quality Management System

The provided answers investigated differences and similarities among private and public hospitals. Based on the standards of Quality Management System, the similarity observed in the private and public sectors stresses the application of distributed leadership in hospital management. In addition, the similarity observed in the private sectors (both in Kermanshah and Tehran) stresses the key role of the top management in the development, which is based on Quality Management System.

Furthermore, the main similarity observed between the private and public hospitals of Kermanshah and Tehran emphasize the environmental requirements. In other words, in addition to stress on the environmental conditions and contextual factors on implementation of quality management, the leader needs to define his/her role in Quality Management System. The private hospital of Tehran emphasizes that the manger be able to perceive the environmental conditions, and accordingly, be able to take effective measures in order to improve Quality Management System.

However, the diversity that was observed in the private sector (private hospitals in Kermanshah and Tehran) stresses its focus on Contingent factors.

6.16.1. Public Hospital in Tehran Case Study A (TCPUB)

The provided responses point out to the distribution of the responsibilities from the manager to the specialist employees; on the other hand, they focus on the manager's

attempts to benefit from the participation of all the personnel in cooperative decision-makings. A glance at indicators and the proposed measures shows that the management needs to develop a set of internal leadership qualities because effectiveness of well-educated and specialized employees in organizations is based on the existence of a democratic space, in which their environmental characteristics will be addressed. The leader of the hospital holds the same idea by saying that:

> *"We currently require the development of management networks on different organizational levels. In addition, everyone should try to serve the role of an effective manager in the organization"*.

In this context, the expert Quality Improvement added that:

> *"The manager is required to use all levels of the organization in decision-making, so that all maintain the enthusiasm to propose new ideas. When done, the movement towards organizational goals can be observed"*.

In this regard, the Patient Safety Expert said that:

> *"Everyone needs to attempt like a manager and avoid hierarchical and organizational charts that result in bureaucratic structures. On the other hand, the manager as an ordinary member of the organization is required to interact with all levels of the organization"*.

The key point to mention in the answers is manager's exercise of power through effective leadership styles. In addition, these responses stress on division (distribution) of

power among members of the organization, so that everyone can put forward his/her opinion in line with organizational activities. In addition, all the employees should regard themselves as a level of managing structure.

6.16.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The answers, as in the case of public sector in Tehran, point out to sharing the leadership power. They also stress the effort of all in entrusting their power in organizational goals framework and in line with the locally based Quality Management System because the external organizational environment (in organizations in general and in hospitals in particular,) imposes different requirements against which the hospitals should prepare to deal with proportionally. In this regard, the head of the hospital maintains that:

> *"The employees who can contribute to the Quality Management System should be categorized in specialized working groups based on their honesty and knowledge. They should also be delegated with appropriate authority"*.

In this regard, the manager of Quality Improvement Office states that:

> *"The manager plays a key role. Actually, the manager is the central axes of the organization and is able to provide equilibrium and balance in it. The manager should be a leader with the ability to guide and influence all his/her staff in order to enable them to move in line with Quality Management goals. Furthermore, it is rendered possible when the manger is forward-looking"*.

Here, the key point to consider is that the respondents believed that the management could not control the employees through policies, procedures, and monitoring. What can lead to success is a strong management culture, which tends towards leadership. Presumably, a leader is required to be willing to share power in his/her role as a leader so that s/he can have an effective management in line with the policies of Quality Management System.

6.16.3. Private Hospital in Tehran Case Study C (TCPRV)

These answers had a particular emphasis on the environmental requirements. In other words, in addition to focusing on the environmental conditions and affective factors, the leader needs to define his/her role in Quality Management Control System. S/He is required to be able to perceive the environmental conditions, and accordingly, be able to take effective measures in order to improve Quality Management System. The leader of the hospital said:

> *"A contingent viewpoint towards hospital issues and Quality Improvement System is a precondition for success".*

The director of Quality Improvement Office argues that:

> *"The manager needs to have the power to analyze the condition of the hospital and face issues based on Contingent Management principles. Like all organizations, a vital factor is to be functional in different environments under different conditions. Consequently, in absence of a true understanding of these elements, an effective management will be impossible".*

6.16.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

In addition to stressing the key role that the top management plays in improving the Quality Management System, the answers stated that s/he is required to include all members of the organization as the beneficiaries in leadership and vying for organizational goals. The leaders are required to identify the potentials among the employees and consequently authorize them proportionally. The Hospital Manager argues that:

> *"Without relying on human resources, the system cannot be functional. Even if the hospital is equipped with modern equipment and the latest technology, in absence of specialized staff, they prove to be useless. Consequently, the manager must be able to optimize benefitting from human resource potentialities".*

Quality Improvement Office manager argues that

> *"The development of services quality necessitates the involvement and contribution of all employees. In this regard, the manager should be able to identify his/her weaknesses. Consequently, s/he needs to benefit from the employees as a complement in resolving the weak points and delegate authority to them in proportion with their abilities".*

The keynote here is the emphasis on the capabilities of human resources. In the present era, the human factor and its unique role as a strategic resource has proved vital; on the other hand, its importance as the designer and the implementer of organizational

processes has gained much more importance than before. Accordingly, as far as advanced corporate thinking is concerned, human factor is regarded as the most important asset for the organization. In other words, if in the past labor, capital, and land were the main factors of productivity, now increase in the productivity of the human resources is regarded as the main factor in the process of development. Thus, it can be argued that an effective and reliable human resource is the strategic asset of any organization.

Figure 6.17 describes Contingency Management, which includes the effective implementation of quality management addressed in internal and external conditions. Another important issue in this model is the existence of distributed leadership in the context of Contingent Management. Contingent Management can be beneficial for performing a more effective role in Quality Management.

Figure 6.16: Distinguish Different Contextual Factors

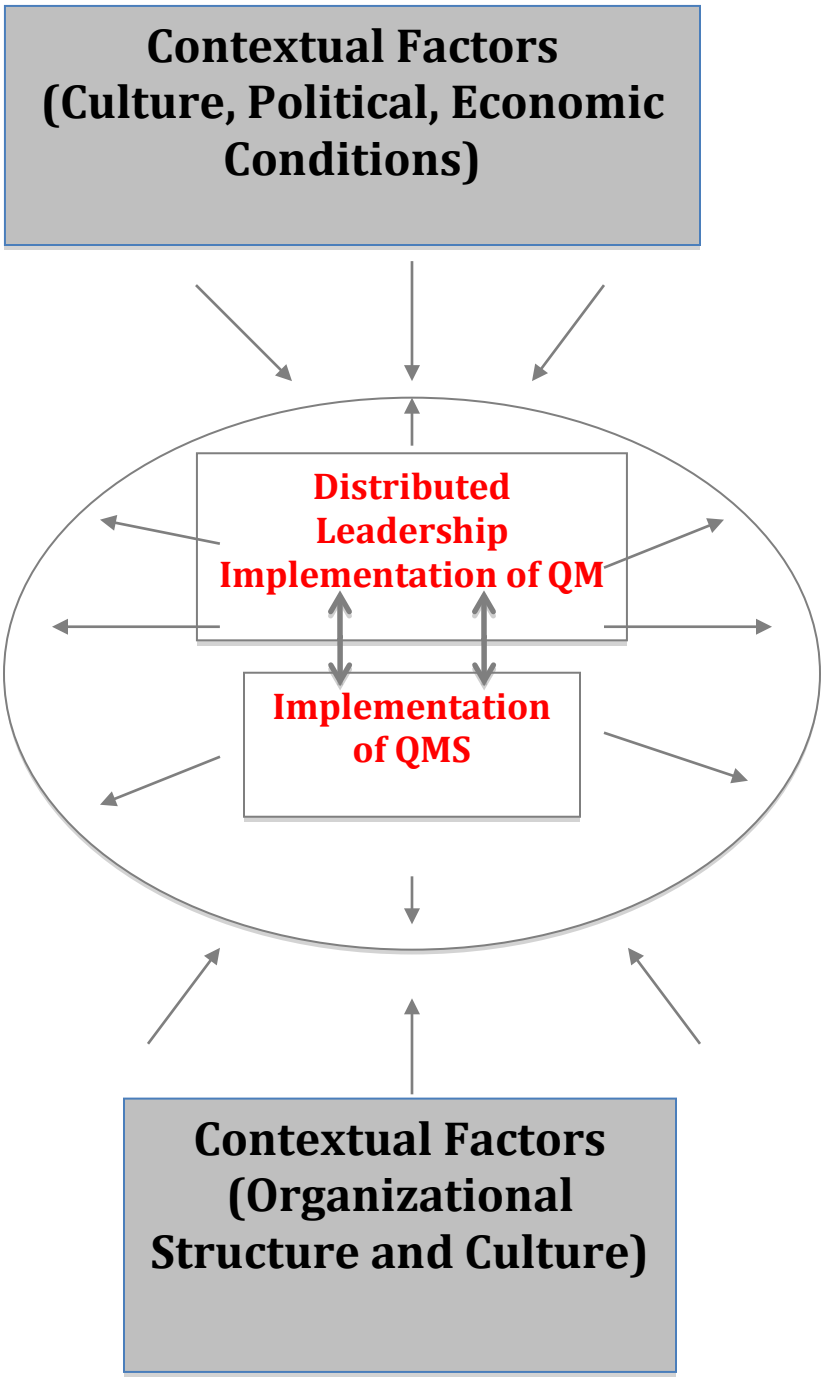
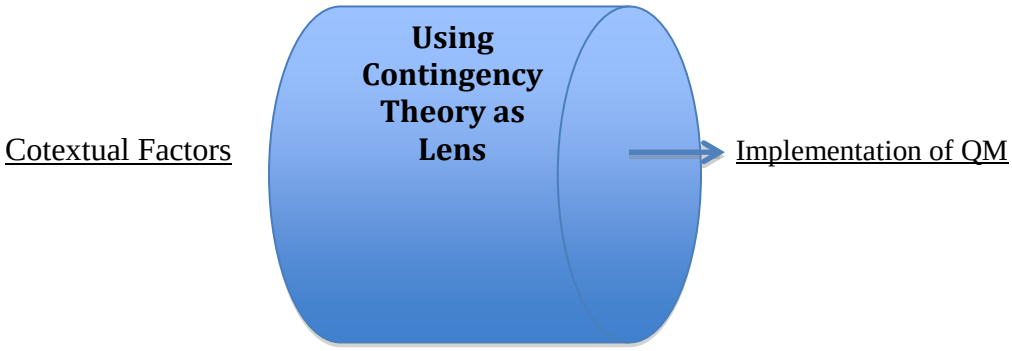


Figure 6. 18 shows how top management can be effective in implementing the Quality management System using contingency theory as a lens to implement quality management.



6.18. Similarities and Differences in Private and Public Sectors Regarding the Implementation of Quality Management System

It can be pointed that the private sector acted more on a customer-oriented basis; while in public hospitals the emphasis is on work-oriented approach. In addition, private hospitals emphasized more on effective management in comparison to the public sector. Another important point regarding the private sectors was the main role of the board direction and hospital shareholders in private hospital.

A similarity observed in the private and public sector was lack of domestication and ability in implementing Quality Management System. Another point was private sector's emphasis on having specialized human source in comparison with public sector. Another significant issue was low reporting and lack of transparency in public hospitals as compared with private sector.

There was a significant difference between private and public hospitals in terms of choosing the hospital chairman. A common view amongst interviewees in public hospitals was that the exclusive dominance of the Medical Science University on the public hospitals plays an important role in all hospital's sensitive and critical plans and background. In addition, this important issue can cause conflicts and challenges between hospital and Medical University. This will ultimately create resistances and make some false beliefs among hospital employees. As mentioned before, the manager's beliefs and the employee's resistance toward change creates barriers in achieving organizational goals. On the other hand, the answers in private sector refer to the Board of Directors and

the shareholders, which play an important role in selecting the Head of the hospital. Consequently, it can dramatically affect hospital's performance and effectiveness. Thus, because the General Assembly knows the hospitals' needs, conditions and contingencies well, it can select someone qualified in order to implement all hospital's goals.

The answers investigated difference in private sectors, which Tehran's private sector's stronger emphasis on the existence of deeper gap between public and private sector, while in Kermanshah it was less. It is also observed that job satisfaction is lower among private sector employees compared with public sector.

Another difference between Kermanshah and Tehran's private sector was ignoring domestication plan. A difference in public sector was Kermanshah's focus on strong points, while in Tehran the focus was on the weaknesses. In addition, another difference between private and public sectors was that the private sector compared itself with advanced countries regarding management system, while public sector did not have such a perspective.

6.17.1. Public Hospital in Tehran Case Study A (TCPUB)

The answers investigated differences and similarities between these two sectors (private and public hospitals). It can be maintained that there were many differences between private and public sector implying a deep gap between them. One should say that the private sector had a good performance regarding customer satisfaction, while in the public sector; the emphasis was on the job security of the staff. In addition, private

hospitals are owned by shareholders, whereas, public hospitals are owned by the government. In this case, the answers also referred to the Head Medical Science University as a qualified figure in electing the chairman of the hospital. Since the Medical University directly monitors the public sector, the public hospitals cannot act autonomously. In this regard, the leader of the hospital maintained that:

> *"There are a number of differences in the public sector: all the employees are full-time and have job security, but in private sector there is no job security…public sector is owned by the government, while the private sector is owned by shareholders. Regarding the physicians' and personnel's communication with patients, the private sector is better. In other words, since the private sector needs to maintain relationship with customers, it treats the patients much better".*

The Quality Improvement Office Manager in this regard stated that:

> "There are *similarities in the type of services presented, but there are differences in choosing the individuals. In the private sector it is tried to choose the qualified people, but regarding the job satisfaction, the personnel in the public sector work better because they have job security. But in the private sector, the focus is on customer's satisfaction regarding hoteling and patient's communication and interaction with the doctors and the medical staff".*

The manager of Hospital in this regard said that:

"While the chief purpose of the private sector is to make profit, in the public sector the issue of profit is just one of the goals. The public sector is under the control of medical university and its strategy must be under the supervision of Medical University, but the private sector is managed more autonomously".

The key point in responses is the reverse relation between job security and quality of the services presented to the patients. Based on the remarks made, it was clear that in the public sector, in spite of job security, there was little satisfactory relationship with the patients. On the contrary, in the private sector it was vice versa. Unfortunately, the public sector does not have a customer-oriented vision to the patient, which ultimately makes the patients unsatisfied with the presented services.

6.17.2. Public Hospital in Kermanshah Case Study B (KCPUB)

The responses presented a little difference between private and public sectors in terms of the type of services offered. Because the goals of both sectors are the same, the differences are trivial, such as hoteling and other less significant features. Furthermore, based on the TM and MM interviewees in Kermanshah public hospital, the exclusive dominance of the Medical Science University on the public hospitals plays an important role on the hospital's sensitive and critical plans. In this regard, the Quality Improvement Office Manager said that:

"There might be different motivations in the private or the public sector. But apparently what people see is hoteling. In other words, because the common aim of all the sectors is treatment, there is not a great deal of controversy. However,

the private sector is managed by an assembly of managers that have more freedom in planning".

The hospital's manager of education in this regard added that:

"In the private sector customer satisfaction is more important, but staffs' satisfaction in the state sector is more focused upon…the Medical Science University Chair chooses the hospital president after reviewing all the cases. [Thus] The public sectors are under the influence of the Medical Science University".

The key point mentioned above is the freedom of the private sector in decision-making in line with organizational goals and programs. This freedom of action is due to familiarity with organization issues and comprehensive knowledge in existing potentialities. It is also based on the fact that it is more consistent with hospital's conditions and atmosphere.

6.17.3. Private Hospital in Tehran Case Study C (TCPRV)

The provided answers showed obvious differences in the context of personnel satisfaction and customer-oriented policies. In this regard, the interviewees emphasized that the private sector had better performance. They said so, because in macro investment policies and hospital goals, the customer-oriented policies are introduced as the motto of the private sector. Here, a notable point is the private sector's freedom to choose the head

of the hospital that is according to required conditions (contingences) and regulations. In this context, the Head of hospital mentioned that:

> *"Customer-oriented policies are important in the private sector which is more customer-oriented than the government sector and attempts to increase the satisfaction level of the personnel. If they see any effective function and effort, the managers of the private sector follow the programs....,* the *Broad of Directors (General Assembly) chooses the hospital chairman in private hospitals that is different from the way that the Chairman is chosen in the public hospital"*.

The Quality Improvement Office Manager stated that:

> *"The public sector can perform its platform better than the private sector, because the surveys and assessments in the governmental sector are more tangible. The private sector does the temporary work regarding Quality Management System and depends on the beliefs of managers and hospital. In the private hospitals, because the Head of the hospital does not believe in the Quality Management System, it is temporarily done and assessed. But in the public hospital, because of a continuous surveying and assessment, Quality Management System is performed and executed better. Regarding the structure, it can be said that in the public hospitals, due to their financial limitations, the managers act more conservatively. If the restrictions are removed, it is more likely that the hospitals in the public sector would have a better performance. The public hospitals are bound to execute predefined plans, surveys and assessment on a constant basis that is not the case with the private sector. Consequently, the*

public hospitals are better in terms of performance and implementation of Quality Management System".

They key point requiring emphasis here is that the private sector tries to maintain the job security of the employees when they act based on their job protocols. This issue is in stark opposition to what the managers of the public sector maintained about job insecurity in the private sector. The private sector pays a high price for similar Social Acceptability programs and various educational plans for its staff, so when employees act in line with their organizational policies, the organization will try to keep them.

6.17.4. Private Hospital in Kermanshah Case Study D (KCPRIV)

The provided answers showed obvious differences in terms of better performance, effective management and customer-oriented perspective in the private hospital than the public sector. It can be argued that the private sector has a special and comprehensive approach to its customers in all its plans even in hospital's presentation. Similar to the Tehran private hospital, in Kermanshah private sector, the Head of the hospital is chosen by the General Assembly. In the private sector, the chairman and the top managers have more and better capabilities because they are chosen based on qualifications and requirements, and not based on the hierarchical structure in the public sector. In this regard, the leader of the hospital said that:

"The private sector considers the customers as the focus of hospital and plans all its activities based on its satisfaction. Compared to the public sector, the private

sector's hoteling is in better. Here management is better than the public sector, and *the chairman is chosen by the Broad of Directors (General Assembly)"*.

The Quality Improvement Office Manager added that

"In management, the private sector is elective while in the public sector it is appointive. The quality management of performance is better in the private sector".

The key point that can be referred to is the way that the managers are chosen in the private and public sectors. While in the private sector, it is elective; in the public sector choosing the top management is appointive. The important point in this regard is criterion for director's decision-making. While in the public sector's appointive method one person is responsible for appointment of the Head of the hospital, in the elective management, it is performed through a council of decision-makers. Freedom to choose the president according to required conditions and regulations could be effective to get competitive advantage and to get coordinated with the external and internal conditions. It can be argued that the instable environment regarding the plans and external conditions makes it inevitable for the hospitals to take a suitable approach. This issue seldom occurs in Iranian hospitals and usually most of the top managers have medical rather than management background. Therefore, choosing the right individual, based on reliable capabilities is a good starting point to improve organizational processes and successful implementation of Quality Management System.

Figure 6.19 describes the differences and similarities in each sector and with regard to the operation of any sector. The second figure describes the contribution of the individuals or organizations in choosing the hospital president in private or state sector.

Figure: 6. 17: Private and Public Sectors Differences and Similarities

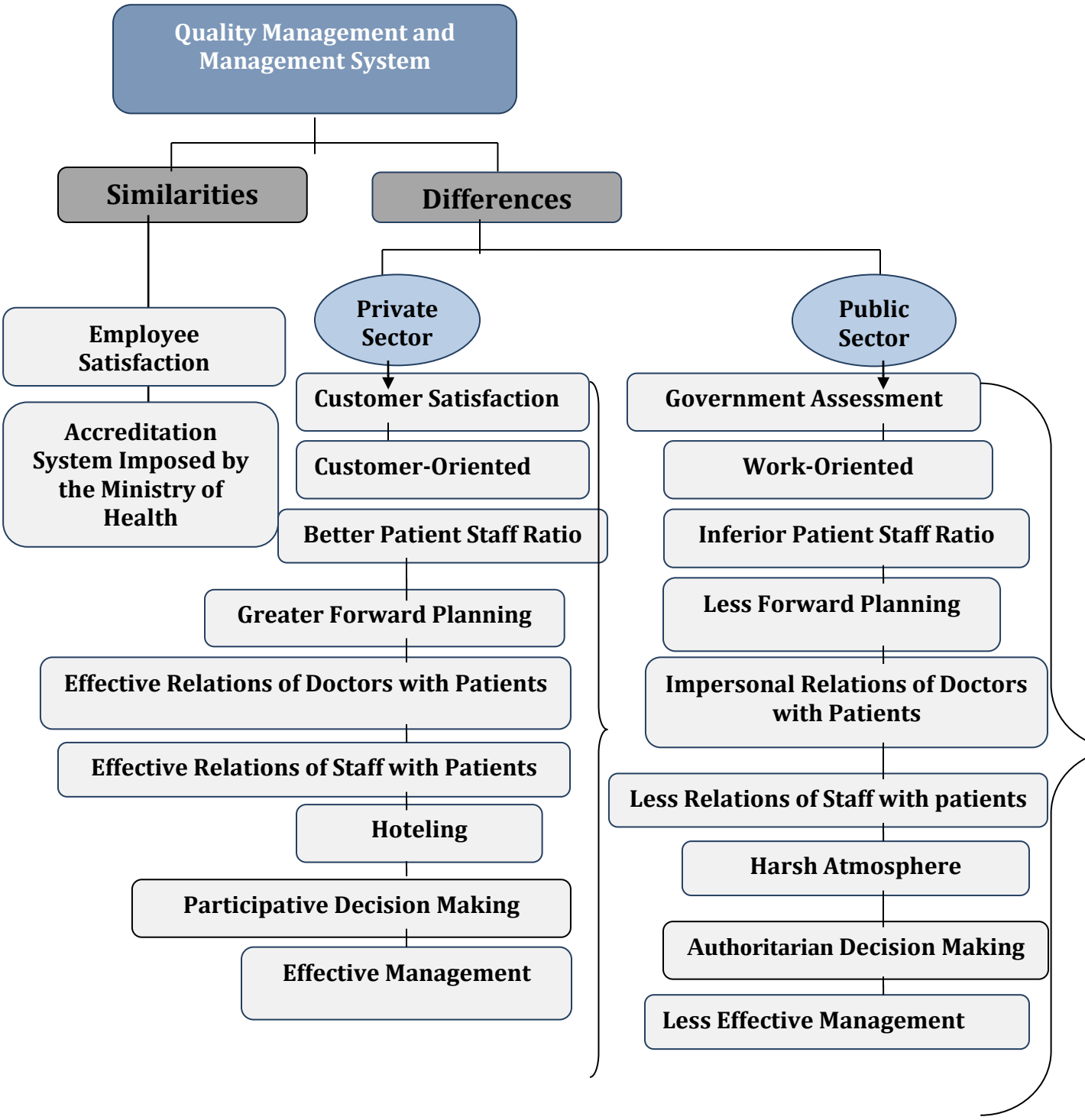
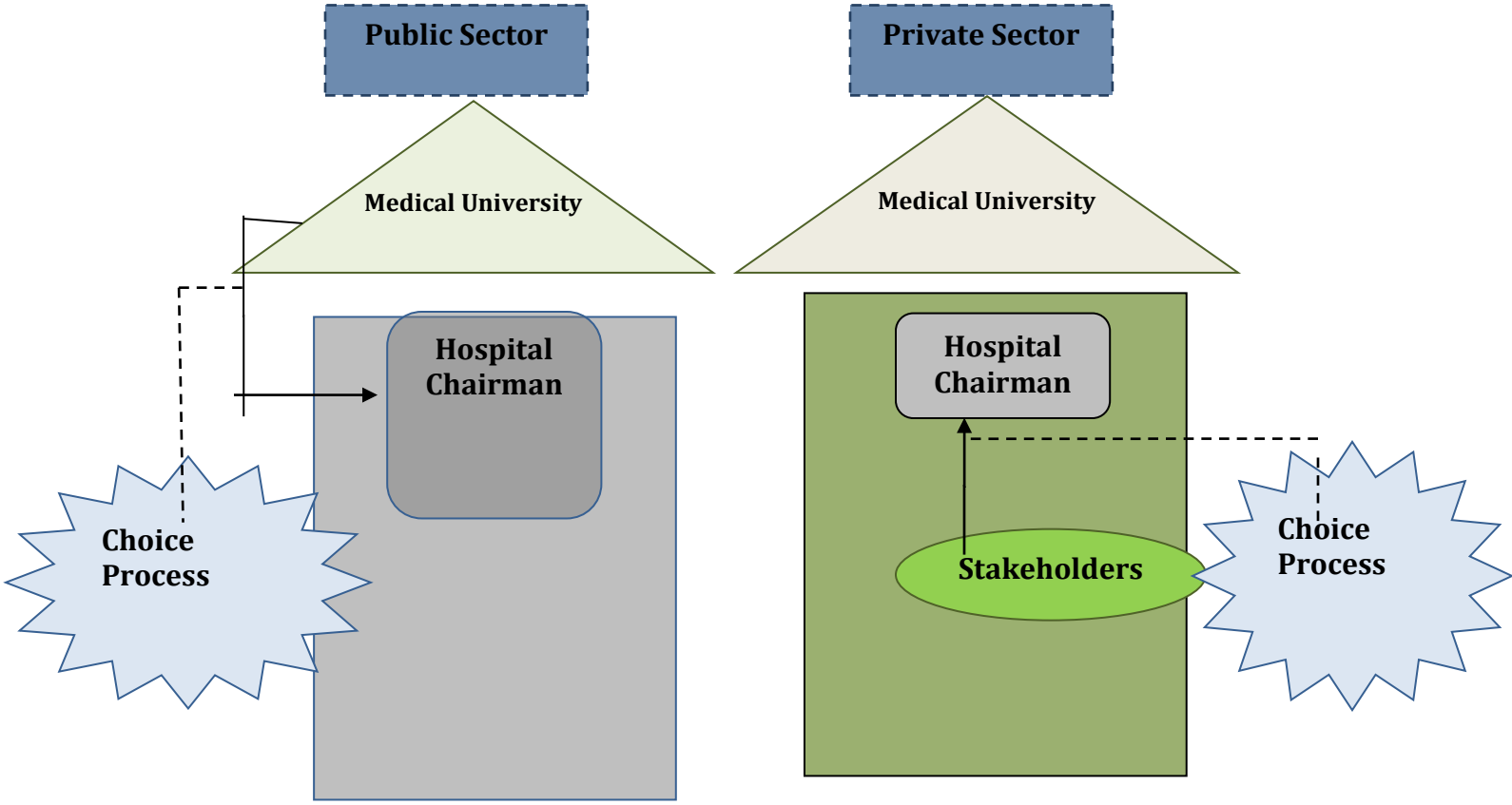


Figure 6.18: Choosing the Chairman of the Hospital



6.19. Summary Chapter

To sum up, this sector has presented the results of the semi-structured interviews carried out in four case study organizations. The purpose of this chapter was to achieve the third objective of the thesis. In order to achieve that objective, a multiple case study was conducted in four hospitals in Iran. The analysis of data was undertaken considering the raw data, and categorizing and presenting it under a number of themes. By selecting case studies as a strategy for this research and using semi-structured interviews as the main tool for collecting data, in-depth information was provided regarding the process of implementing Quality Management System in the four hospitals. This sector has examined the responses of interviewees to 17 questions presented in the interviews. To improve the internal validity during the analysis, multiple sources were used including: documents, quality manuals, minutes of meetings, organizational structure, and quality plans.

Generally, these results indicate that both public and private hospitals have dissimilar governance and ownership constructions. However, both private and public sectors face similar issues in relation to the intellectual nature of their principal tasks. In addition, these results indicate that there are some similarities and differences between private and public hospitals in Kermanshah and Tehran. Consequently, these results show the key similarity between publics and private hospitals is that all hospitals are obliged to act based on the Health Ministry policies. The Health Ministry is the sole decision maker in the present pyramidal structure. The decisions are made on the highest level and are transformed in connective channels to the low level of pyramid. These results show that

Quality Management Systems modeling have been copied from developed countries (such as the USA and European countries) without being customized and coordinated with Iranian climatological and cultural conditions. As a result, contingency theory is needed to be taken into account. These results suggest that the most significant difference between private and public sectors was in terms of choosing the Chairman. While in the public sector, chairman was chosen by the Medical Science University, in private sectors the general assembly chooses the chairman of the hospital. The key difference between private and public hospitals was that in private sector the focus was on a customer-oriented approach of Quality Management System, while in public hospitals the emphasis is on working procedures (work-oriented approach). In addition, private hospitals emphasized more on effective management in comparison to the public sector.

As the final remark, these results indicate that hospital leadership has a significant role in implementation of Quality Management System. Furthermore, this study suggests that distributed leadership needs to be utilized by top management. In the following chapter, the results will be discussed.

7.0. Introduction

This chapter is concerned with achieving the three objectives of the study, namely, analysing and comparing quality management approach in hospitals in Iran with theoretical perspectives to examine the implementation of quality management systems in Iranian hospitals with particular emphasis on the role of leadership. As explained in chapter four, to achieve this objective, the researcher conducted a multiple case study in four hospitals in Iran. As explained in chapter four, the researcher used a cross-case synthesis to analyze data obtained from the field study.

This chapter will discuss the empirical findings of the four case studies, link these with the findings of the literature review, and consider the research implications. The field study results are thus reviewed in the context of previous findings and theoretical explanations in order to draw both practical and research implications. The basis of the discussion will be the similarities and differences between findings identified in the literature review and the corresponding findings of the case studies. This will also provide opportunities to discuss any new issues emerging from the case study findings not predicted in the literature review. In relating the findings to the previously reviewed literature, a better understanding will be gained of the similarities and differences between hospitals in Iran, as represented by the case studies, and hospitals. It is finally

continued with evaluation of the contingency theory (the theoretical framework of this thesis) in the context of implementation of quality management.

Using a Case Study of Iran:

7.1. Case Study Discussion

The following sections (7.2 to 7.3) present a discussion of the results of the research objectives, considering the differences and similarities vis-a-vis the literature reviewed in chapter 2, 3, and 4. The findings unique to the Iranian environment will be underlined.

Using a case study of Iran:

7.2 Objectives

7.2.1 Quality and Quality Management

The first step to start the discussion would be presenting a definition of quality based on the ones given by the majority of the subjects interviewed. There are many definitions of quality; however, there is no single and universally accepted definition of the phrase, but there is a range of interpretations for it. According to Pirsig (1974), the notion of quality is as elusive as it is pervasive. The difficulty of definition consequently makes it difficult to attain worldwide agreement on the notion. Therefore, instead of attempting to impose a worldwide definition of the term, diverse definitions of quality have been utilized depending on the conditions (Garvin, 1988; Reeves & Bednar, 1994, Stensaker, 2004).

However, the presented answers regarding the definitions of quality refer to design and compilation of standards and the indexes of ideal performance. By following the correct processes, one can reach the effectiveness and efficiency index of an organization, and eventually the customer's satisfaction can be materialized. It is interesting to note that only in two cases (private hospitals) of this study, the term quality is defined as the operational planning, which starts with the organized planning and ends with the customer's satisfaction. As mentioned in the literature review, to confirm comprehensively what is meant by *"quality"*, it is significant to define the relevant terms of quality management (Aravindan et al., 1996). According to the literature review, there are many definitions for quality such as, *"fit for purpose"*, *"right first time"*, *"what the customer wants"*, *"conformance to requirements"* and *"value for money"* (Deming 1986). From literature review, the first step to comprehensive quality management is highly related to the definition of quality.

An initial objective of the research study was to identify *"what kind of quality management systems do Iranian hospitals use?"* Analysis of questions based on conducted interviews indicated that quality management system currently in use in Iran's health centers is a part of accreditation-integrated model in all parts of the country mandated by the Ministry of Health and Science. However, this result has not been described in literature. It is worth mentioning that the Accreditation standards can be considered as a QM followed by healthcare organizations to develop quality and patient safety through stressing constancy of care. Accreditation standards are defined as

"stimulating demonstration of continuous and sustained improvement in health care organizations by applying international consensus standards and indicators" (Joint Commission International, 2003, p1). As Dale (1999) notes the goal of QM is to create an outline to promote stability in the institute. According to JCI (2003), the followings are several significant characteristics that can be utilized by healthcare institutes:

- It needs leadership, involvement, and commitment of all healthcare providers in the implementation procedure.
- Internal and external audits are utilized to compare each institute's presentation with its own audits.
- Constant self-assessment is encouraged to guarantee the stability standards implementation.
- Internal assesses of the medical certification and annals of healthcare providers ought to be conducted to recognize development level.

As McFadden et al. (2006) point out the JCI standards constitute a QM framework for hospitals with great stress on the implementation of patient safety approaches. The implementation of patient safety denotes the procedure of carrying out certain approaches such as education and training, open discussion of errors, and system redesign the system to diminish patient damage and medical faults.

Some countries (such as Iran) and healthcare institutes outside the United States are seeking their services and employ their standards in an effort to develop the quality of

their services to meet international standards. The results of the present study indicate that over the years, quality management systems in the Iranian hospitals have been on an increasing trend. Based on the timeline of quality management system, historic profile of Quality Management System indicates that since 2005 to 2015, more than six QMSs have been implemented. So far, quality management system has brought about positive changes (for instance improving the hospital work procedures, services quality, and presenting a feedback to management about quality management system) in the Iranian hospitals. However, the hospital is still facing problems in the implementing quality management system. This result may be explained by the fact that accreditation system, while creating a clear and specific criterion for assessing the quality management system, has its faults, including lack of native program of quality management system in accordance with the type of every region's cultural, social and ethnic structure in Iran. Most interviewees from four case studies emphasize that the regulations dictated to hospitals by the Ministry of Health and Medical Education about quality management system doesn't consider general, social, cultural, economic, and geographical conditions. According to Foster, (2006) taking a one-size format, fitting all methods to quality management may not lead to better results. Different organizations may require different methods to quality management. Some scholars have started to develop a refined understanding of quality management by drawing on contingency theory. For example, Foster (2006) notes the importance of taking a contingency theory perspective when implementing QM. Consistent with Foster (2006), Sousa and Voss (2008) also raise doubt about the *"universal validity"* of quality management practices. This research also investigates the important effect of context on implementing quality management. This

finding is supported in the literature by Sousa and Voss (2001, 2008) who recognize the importance of contingency theory in Operation Management. Prior studies have noted the importance of contextual factors influencing quality management effectiveness, such as country (e.g. Oliver et al., 1996; Rungtusanatham et al., 1998, 2005) and firm size and structure (Ghobadian and Gallear, 1996; Ahire and Golhar, 1996; Sila, 2007). In addition, Jayaram et al. (2010) examine the effect of unionization, firm size, quality program duration, and industry context on implementation of quality management. The current study found that Iran has its own ethnic character consisting of its own unique culture, language, and characteristics. The characteristics of Iran accompanied by different geographical structure, different cultural conditions and levels of facilities and structures have created a heterogeneous texture throughout the country. It seems natural that the present integrated quality management system faces with obvious heterogeneity for implementing and enforcing quality management system. Furthermore, when the hospital customizes a quality management system, it can get better results. Being familiar with conditions, structure of hospital, and system design are reasons for this claim. The most important finding was that the review of QM in Iranian hospitals over a ten years period suggests that QMS will not achieve maximum success unless it is adapted to local conditions or contextual factors.

In reviewing the literature, Westphal et al. (1997) studied implementation of quality management in hospitals, and discovered that hospitals customizing the quality management practices had higher performance than hospitals that adopted standardized approaches to quality management. However, their study did not offer an explanation

about how organizations can customize quality management practices. The present study draws on contingency theory and empirically indicates that the contribution implementation of quality management practices depends on internal and external factor such as organizational structure, organizational culture environmental contextual factors an also top leadership.

The other results of the present study focused on the centralized and hierarchical (pyramidal) organizational structure of medical centers. It means that the Ministry of Science is responsible for decision-making and adopting programs, which in turn are handed down to lower level structures, namely hospitals. Centralized organizational structure while creating a structure of accountability and focusing on unity of leadership and forming a uniform structure in the organization is associated with problems such as resisting toward change, lack of use of all human resources potential, lack of coordination between the plan and the existing situation (internal and external factors), lack of team work, lack of motivation in personnel, individual-organizational contrast, individual-organizational lack of coordination, low job satisfaction, not welcoming ideas (comments) of the staffs and creating inflexible structure. This finding is consistent with studies by Burns and Stalker (1961), Daft (2004), Yasai-Ardekani (1989), and Gharajedaghi and Ackoff (1984), which identify two types of models, which have been used to describe organizational structure: mechanistic and organic. A mechanistic structure employs hierarchical and centrally controlled organizational relationships (Burns and Stalker, 1961. An organic organizational structure has fewer levels and open internal arrangements (Spencer, 1994). Research on organizational structure indicates

that a mechanistic structure has a stabilizing effect on organizations whereas an organic structure encourages creativity and adaptability (Eisenhardt and Tabrizi, 1995). According to Cole and Scott (2000), organizational structure can support QM effectiveness. Douglas and Judge (2001) suggest that organizational structure moderates the relationship between quality management and performance. Their research uses data from hospitals and finds some support for the moderating role of organizational structure. However, Douglas and Judge (2001) did not investigate the role of hospital leadership in implementation of quality management practices, and their conclusion implies that both highly mechanistic and organic structure positively moderate the relationship between quality management and financial performance. Therefore, their study does not provide insight into how to customize the quality system to match different contextual conditions. The present study argues that organizational structure influences the effectiveness of implementation of quality management. As mentioned in the literature review, quality management practices benefit from a mechanistic structure since more hierarchical levels of the organization narrow the span of control. In contrast, an organic structure has more open and flexible internal relationships. Organizations with more hierarchical levels have narrower or tighter spans of control and thus a more mechanistic structure; whereas fewer hierarchical levels allow for more flexible and open internal arrangements (Burns and Stalker, 1961; Daft, 2004; Yasai- Ardekani, 1989). Claver et al. (2000) report similar findings and state that a bureaucratic management causes many problems for organizations, such as lack of employee involvement, insufficient investment in technology, hierarchical levels, inappropriate planning, inappropriate business alliances and not being able to adapt to the market. Awan and Bhatti (2003) also found that the

lack of a quality culture, centralized decision making and high turnover were inhibiting factors in starting the quality management system process in Pakistan. The most obvious finding to emerge from the analysis is that centralized organizational structure (mechanistic structure) while creating a structure of accountability and focusing on unity of leadership and forming a uniform structure in the organization is associated with some problems in implementation of QM in public hospital which are more hierarchical in structure. In other word, the public hospitals have more mechanistic structure; thus, this does not end up in having an effective QM whereas in the private hospitals, which seem to be more organic structure, it led to having a more effective QM.

However, this study argues that while considering situation or circumstance geographical and structural situations needing to customize quality management system with circumstance each case and also needing a flexible and native structure accompanied with high freedom and authority in order to have high productivity in line with implementing quality management. This study argues that organizational structure as internal factor influences the effectiveness of implementation of quality management. Based on the literature review, an organic structure has more open and flexible internal relationships. In contrast to mechanistic structure, most interviewees from different levels of four case studies agreed that the pyramidal structure is a significant barrier to implementing quality management system.

In terms of the barriers to implementing quality management, several barriers were highlighted in the four cases, which can be divided into external and internal factors.

Internal barriers are limiting factors to the implementation of quality management system organizational structure, organizational management, economic factor (financial problem), centralized system, inadequate education, organizational inflexible atmosphere and culture, lack of precise evaluation, time, lack of enough relationship between management department and other sections can limit the effective and suitable quality management system and most importantly the managers' beliefs. Regarding the external factors, hospitals face social, political and economic restrictions and in a broader view the equipment and drugs shortage, being far from the center (Kermanshah City case) and in the more and macro view, the economic sanctions as external factors are introduced as limiting agents of quality management system.

Here some of the barriers are explained in more details:

The first unique finding of this study related to barrier of implementing quality management in both public hospitals in Tehran and Kermanshah was that the top management is unaware of the benefits of quality management (Accreditation). This is due to lack of monitoring and support of the top management in the process of implementing QM in all the levels of organization. This is supported by AI-Zamany et al. (2002) and Wong (1998), who argue that the implementation of QM in developing nations may fail due to understanding and a lack of awareness of quality management. The failure of various institutes to gain accreditation is due to the poor understanding of top management and other concerned managers about the needs of the implementation process and QM standards.

Another barrier in public sector was inadequate quality management system training and unawareness in observing the standard requirement. In addition, some of the terms used in the standards could be ambiguous, vague and imprecise which will cause lack of QMS understanding in the organization. In the present study, some of the middle managers interviewed in public hospitals felt that the vision of the leadership regarding quality management was not clear to all the staff, which is related to the first point by Kanji (1998). Czuchry et al. (1997) quote Latham (1995) as emphasizing that vision is a vital factor in organizational success. They also emphasize that management should motivate its employees to believe in the vision of the organization as a key to successful change.

Another significant barrier in case studies (public hospitals) was lack of decentralization. According to Stutts and Wortman (2006), decentralization is the process of distributing authority throughout an organization. Similarity, according to Dale et al., (2007) one of the significant issues in implementing quality management system is the organizational structure. The approach that the organizational structure facilitates and compliments the adoption of a quality management system is vital in a successful implementation. In a decentralized organization, a supervisor or member of staff has the right to make a decision without obtaining approval from a higher-level manager. Centralization is the retention of decision-making authority by top management. This barrier was highlighted in the hospital as the improvement quality manager office expressed her dissatisfaction that she is not fully authorized to make quality-related

changes without having the green light from the chain's board of directors. This barrier might affect the implementation of a quality management system, as it might lead to service failures and consequently, customer dissatisfaction (Dale et al., 2007).

The results of this study indicate that the most significant barrier highlighted by almost all participations in private and public hospitals, was that quality management system is copied from the introduced models by scholars and researchers in America and the Europe without required modifications. In other word, almost all interviewees point out that quality management systems have been copied from developed countries without customizing coordinating it with every country's climatological conditions and culture. As mentioned in the literature review, organizations require the understanding as to how to implement quality management system to accomplish the maximum benefit (Sousa and Voss, 2001, 2008). A ten years experience of Medical Services Centers in Iran along with using quality management in the hospital verifies that using quality models without domesticating (customizing) and coordinating cannot be accompanied with good productivity and implementation.

One interesting finding about barrier to implementing quality management system highlighted in private hospital (Kermanshah) was the time in implementation of quality management system strategy. Implementing a change in the quality management system is time-consuming. Failure of the medical service sector to take this required time into consideration causes some problems. The leader of Kermanshah private hospital mentioned that during 10 years, eight quality management systems have been

implemented in the medical services section in the private and public sections. If there was a preplanned time for every project, naturally we could yield better (effective) results and fewer changes in the quality management system. Top manager and middle manager interviewed stated that shortage of time was one of the barrier factors throughout the implementation of quality management process, since the contract between Health Ministry and the quality management system specified that the four hospitals had to complete the project within certain month. The timeframe of the contract was decided following the advice from the Iranian Government whose strategic plan emphasized the requirement to offer private and public healthcare services in Iran at an international standard. Sharp et al. (2003) identifies a similar barrier and adds that the failure to allow sufficient time for evolution was a barrier to successful implementation of ISO 9001 (2000) by organizations in the UK. Following the work of many authors, the researcher concluded that the implementation period of any quality system should be adequate to cover every parts of work in each department.

Another important barrier of implementation of quality management is resistance to change. There was broad agreement among interviewees in four case studies that resistance to change at all levels of staff was mainly clear at the beginning of the process. This was linked to shortage of awareness and information about the nature of the quality management system process. However, any remaining resistance to change was linked to culture and staff motivation, and human resource practices. The leader of hospital public hospital said:

> *"At the beginning of the procedure, we had significant resistance from*

administrators and physicians, since they thought the procedure of implementing the new QM in the hospital was going to raise their workload".

The top management of private hospital in Kermanshah desired all quality work to be carried out through the Improvement Quality Office (Quality Department). This implies lack of understanding and awareness by top management of the realities of implementing a quality system. According to McFadden et al. (2006) one of the feasible activities to develop implementation of quality management is expanding top management support and developing identification of their employee.

In several reviewed documents such as action plans and minutes of meetings, the researcher discovered that the top management of four hospitals followed some strategies to reduce resistance to change, which are as follows:

- Regular training, orientation and information delivery to staffs.
- Consistent meetings of all hospital personnel with the leadership and quality directors to support their commitment and share their performance-related information.
- Hospital-wide newsletters to inform the personnel about the development of the implementation of QM process.
- Regular participation of all the concerned administrative, nursing and medical staff.
- Constructing brochures covering queries and responses regarding significant

problems in relation to the responsibility of different employees in the QM implementation.

- Constant performance assessment about development regarding implementation of QM.

Several of these strategies are supported by Raymond (2002), Paton and McCalman (2000), who clarify that resistance to change can be overcome by appropriate performance calculation systems, effective participation, communication, and teamwork.

The following reasons for resisting change recognized throughout the literature review were not observed in this research study:

• Fear of the unknown: not considering what is occurring or why.

• Disrupted habits: feeling distressed while old systems of running things cannot be followed.

• Loss of confidence: feeling incompetent to perform well under the new approach to work

One of the main findings of case studies of Kermanshah (both private and public) and public hospital in Tehran, regarding cultural issues is related to the bureaucratic style of management at the head office. A possible explanation for this might be that the decision making in the central departments, which report to the head office was centralized inside the departments and greatest amount of the work done by departments was paper-based. These documents were shifted from table to table in different departments, consequently

making ultimate decision-making very slow. According to Claver et al. (2000), a bureaucratic culture causes many difficulties for institutes, such as insufficient investment in technology, lack of employee involvement, inappropriate planning, and hierarchical levels. Similarity, Awan and Bhatti (2003) discovered that centralized decision-making, and lack of a quality culture were inhibiting elements to starting quality management process in Pakistan. The most significant challenge associated with these case studies was heavy bureaucracy, and the imposition of too much paperwork affecting slowness in the decision-making procedure.

Support for this finding is provided by Al-Khalifa and Aspinwall (2000), who found that the bureaucratic culture was dominant in Qatari firms. They also claim that employee resistance to change and cultural change were the main cultural obstacles encountered in implementing QMS standards in Qatar. This factor of bureaucracy was very much obvious in the style of management of the Ministry of Health connected departments, as stated above in this segment. The researcher realizes the similarities between Iran and Qatar, which might lead to similarities in their organizational cultures. Several managers in four case studies stressed the requirement for efficient training programs, quality orientation, more job awareness, and workshops.

Based on the literature review in Chapter Two and the discussion of the findings, the researcher has derived the barriers of the implementation of quality management in Iranian hospitals (both private and public). According to the literature review and what other researchers mentioned earlier in this chapter and in Chapter Two, it is obvious that

most authors have considered inappropriate organizational structure, lack of top management commitment, and resistance to change. However, literature highlighted some barriers (such as lack of synergy between quality improvement programs and overall business strategy, lack of rewards and recognition and lack of focus on the process), which were not found in this research study. As discussed in the interview answers, this research study found that there are similar and different barriers to quality management applied to four hospitals.

It is interesting to note that in the field of managers' beliefs, this research can claim it is a key agent in the advancement and optimal use of quality management system. When the top management believes that the quality management improves the organizational performance and tries to achieve it, the staff will work more efficiently. The hospital's leader also plays a supportive role in implementation of quality management. However, as long as managers do not believe in the system, the hospitals not only hospitals will face problems to implement quality management system, this wrong attitude would spread among the staff and finally, it will end up employees' resistance to change.

One of the main findings of the present study is the significant role of organizational culture in affecting the implementation of quality management system. Since quality management system in organizations is a kind of organizational change, to design and implement it effectively, the organizational culture must be studied and measured first (Dale et al., 2007). Thus, there is an agreement that organizational culture needs to be completely included in the implementation of QM (Skerlavaj et al., 2007). In numerous

research studies, it is believed that (Maull et al., 2001; McNabb and Septic, 1995; Westbrook and Utley, 1995) quality management can modify the organizational culture and also, as other research study indicates organizational culture affects QM and its outcomes (Prajogo, 2005). On the other hand, the considered environment must be prepared to accept change in culture in order to have necessary readiness to apply any quality management. For the implementation of quality management, it seems that suitable organizational culture is necessary, as quality management is a continuous activity that should be rooted in organizational culture. The organizational culture specifies the amount of quality management system acceptance in an organization. Of course, organizational culture is considered effective in this case, since the individual's culture and even culture that the individual in which he is brought up are effective in this case.

7.2.2. Leadership and the Role of Top Management Hospital Leadership and Commitment

In terms of defining leadership, different definitions were given in the four cases. The present study has identified the similarity and difference of the provided answers. The significant similarity in all responses was about hospital chairman definitions from different views and perspectives. Therefore, some of respondents in both case studies of public hospitals believed that leadership is defined as the skill of motivating a group of people to achieve organizational objectives. This definition was also used by (Oakland, 2003). Many top managers and middle manager interviewed in private hospitals defined leadership as the skill of communicating with a group of people. Furthermore, some

interviewees also believe leadership involves influence, without which, leadership does not exist. Leadership was also defined by some interviewees as creating the communication linkages with followers.

Another important finding refers to lack of clarity over how to describe the chairman's role. This result may be explained by the fact that the top management has two complementary roles of leadership and management; leadership by having charismatic characteristics and ability to influence and establish effective communication with subordinates trying to advance organizational goals; management by having special ability and coordination and directing they try supervision and patron ship in accordance with organizational goals. While considering the significant differences in the features of leadership and management, it should be noted that both complement each other. On one side, the leadership role of the chairman includes directing financial and information sources to the organization. On the other hand, the managerial role of chairman includes managing the human resources to achieve the objectives of the organization.

However, the difference in the case of Tehran and Kermanshah public hospital was Tehran's emphasis on the aspect and role of leadership in defining the hospital as a president, while in Kermanshah the emphasis was on managerial aspects. One can say that this difference was seen in Tehran and Kermanshah private hospitals. The significant difference in private and public hospitals was that the public sector has narrower perspective (or unclear vision) toward hospital chairman roles as opposed to private section. However, the present study identified that leadership can have different

meanings for different people.

Again, like defining the concept of quality, there was no comprehensive definition regarding the definition of hospital leadership.

It is interesting to note that in all four cases of this study, interviewees have their own assumptions and definitions for leadership based on individual experience and perceptions. From different perspectives of interviewees this research study has identified that leadership cannot be suitably defined in terms of the actions and features of individuals. Instead, it is more effectively viewed as a dynamic process, which can be used as an abstract ideal through which one can understand complex organizational phenomenon, rather than a fixed and observable event. These results are consistent with those of Kelly (2008), and Osborn, Hunt, & Jauch (2002) who believe that this view permits investigation of organizational phenomenon in a fluid and contextual manner, as opposed to being compelled by a singular, practical definition of 'leadership'.

Another important issue in line with management in hospitals to be considered is a kind of participation management in the organizational structure. Of course, requirements of hospital and present circumstances indicate the need for all staff participation in all levels especially in quality management system. It is very important that the top manager and middle managers in public hospitals realize the inflexible management structure does not have the capability to implement modern management system. Therefore, with centralized medical system and inflexible official hierarchy in Iranian hospitals being

directed from the outside in public hospitals, no one can expect to implement modern management system (organic structure). The organizational structure of the public sector is not compatible with the organic structure. Despite a centralized structure in all medical centers in Iran, the majority of interviewees stated that there is an ongoing pattern of participation in decision-making between top and middle management. Analyzing the responses further revealed that in public hospitals there was some participative management. This participation was limited to top managers who were able to make decisions, and the director was the ultimate decision maker whereas in private sector hospitals organizational structure was more participative.However there was broad agreement among interviewees in both case studies of private hospitals regarding the pattern of leadership that in general classification refers to organic and open system and specifically introduced the participative management, since every organization trying to go ahead and be successful has to extend the decision making to the lowest operational level, since in this level personnel are more familiar with the organizational problems and issues and can offer their ideas effectively.

The current study found that the some interviewees were completely ignorant and unfamiliar with managerial issues. This fault can be because staff's post does not correspond with their educational degree. For instance, one quality management manager (the quality improvement office manager officer) thinks that the scientific management about flexibility which are reviewable with Taylor's comments and ideas, as it is clear that Taylor, as the pioneer in scientific management, believes in traditional and inflexible structure, in which the managers and personnel are merely stimulated by the economic

factors which are mobile factors in organizational structure without interference in decisions.

Returning to the main research question of *"What is the role of top management hospital leadership and commitment in implementation of quality management system?"* this section will now offer insights into this question.

The current study has examined top managers and middle managers' perception on the role of top management hospital leadership and commitment in the implementation of quality management system in private and public hospitals. Generally, leadership roles in implementing quality management in the hospital are reflected in the responses of senior leaders (top management), and middle management does not appear to be different from the findings of other studies; however, this study focuses on the case of Iranian hospitals. Most interviewees at all levels in four case studies believed that the top management plays a key role in implementing quality management for their hospitals.

This finding is consistent with those of Ah Rahman and Tannock (2005), who found that in Malaysian firms in which top management plays an essential role in developing quality of all categories in the organization, TQM is better performed. Top management may go beyond the commitment to the quality programme in the institute by being dynamically engaged in the implementation procedure themselves and thus be considered as role models in this procedure. The effect of top management involvement in implementing quality systems to create a TQM culture was studied in the reviewed

literature. As Kanji (1998) noted leadership ought to be dynamically engaged in generating a TQM culture with a clear vision across the following top management roles:

- To define a mission, vision and goals that promote a Quality Culture:
- To define a quality strategy;
- To create a set of shared principles;
- To better manage utilizing the assets in order to develop financial presentation;
- To launch purposes and systems to improve customer satisfaction;
- To communicate and motivate constant development;
- To launch efficient data systems and utilize objective information;
- To support the improvement of human resources recognition and training;

In the present study, some of the middle managers interviewed felt that the vision of the leadership regarding quality management was not clear to all the employees, which is linked to the first opinion as underlined by Latham (1995), Kanji (1998) and Czuchry et al. (1997) since they claim that vision is a fundamental component in success of organization. In addition, they assert that leadership ought to motivate its staff to be considered in the vision of the organization as fundamental to effective change. As Kanji (1998), Czuchry et al. (1997) and Latham (1995) noted that including motivating staffs in the vision of the institute, subsequently develops the foundation for the creation of the institute's values and vision, which was missing at the start of implementation of QM procedure in four case studies. Another important issue among the top managers in

hospitals is that they were not committed to quality implementation in the beginning because of the shortage of support from the headquarters of the hospital. This shortage of involvement was reflected in participation in quality performance at the beginning of the implementation procedure. Support for this finding is provided by McFadden el al. (2006), who emphasies on the role of hospital leadership commitment in the study of implementing quality and patient safety in US hospitals: the more commitment and stress the hospital and patient safety top management place on quality and patient safety initiatives, the more possible the hospital is to really implement them.

According to these data, we can infer that the top management did not communicate the organization's vision well to diverse groups of staff in each hospital; hence, the vision was not shared by the middle managers that should have been involved. A quality manager improvement office said:

> *I do not know what top management is. Their objectives are not clear to us; they have not discussed the qualify objectives with us.*

This finding further support the idea of many other authors, such as Campbell (1995), Mostafa (2004), Sharp et al. (2003) and Hoffman (2002) who support that vision should be very clear to all staff. Quazi and Padibjo (1998) found that lack of top management commitment was a barrier to the implementation of quality management in organizations in Singapore. Similarly, Goetsch and Davis (2000) support the requirement to communicate the benefits of the quality management to the staffs for continuous development.

Because the top management was not involved in the process of implementing quality management in the four hospitals at the beginning of the project, the staff suffered lack of support. The top and middle managers at the four hospitals confronted many challenges from the central departments reporting to the headquarters leadership, due to this lack of involvement and commitment. Some of the leaders of the headquarter departments were committed to the process; however, they were not completely aware of their accountability to facilitate the implementation of quality management. This finding is consistent with those of Sharif (2005) and AI-Haj (2006).

The results showed that Quality management is not an issue that can be institutionalized alone or by one sector. Consequently, there is a need for public cooperation in this field.

The other topics of the organization's hospital management are a power (authority) pyramid between managerial, government and medical specialists. This pyramid in the private and public sector is powerful in different service centers. The significant differences of private and public sections are that in private section the managers are on top of strategic pyramid while in public section government and specialists have more powerful dimension in the trifocal pyramid. Naturally, the public centers are more affected by the government regarding the state budget and sponsorship. In contrast, medical specialists in public section have more power regarding their strategic role and hospital's need. A notable point in line with specialists and their power is the existence of

conflict in managers' strategy, which can be traced in doctors and management one-dimensional approach to hospital and paying attention to individual goals versus organizational goals. It is also rooted in managers' weak interaction and lack of effective communication between managers and physicians, that eventually appear in both groups performance and plans.

In response to the question "*How can managers perform an effective role in the context of Quality Management System"* all respondents stress the division of power among members of the organization, so that everyone can put forward his/her opinion in line with organizational activities, and all the employees should regard themselves as a level of managing quality system. The most important relevant finding was the majority of interviewees believed that the top management could not control the employees through policies, procedures, and monitoring. What can lead to success is a strong management culture, which tends towards leadership. The leaders are required to be willing to share power in his/her role as a leader so that s/he can have an effective management in line with the implementation of Quality Management System. These results corroborate the ideas of Pearce and Conger (2003) who went on to elaborate on the basic nature of shared leadership, viewing that leadership is "*broadly distributed…instead of being centralized in the hands of a single individual"*.

In additional, it is interesting to note that in all four cases of this study the emphasis was on environmental requirements. There was broad agreement among interviewees in four case studies that leaders should focus on the environmental conditions and effective

factors. The leader also needs to define his/her role in Quality Management System. The leader is required to be able to perceive the environmental conditions, and accordingly, be able to take effective measures in order to improve Quality Management System because the external and internal organizational environment (in organizations in general and in hospitals in particular,) imposes different requirements against which the hospitals should be prepared to deal with proportionally. Consequently, in order to move in line with the standards of Quality Management System, considering Contingent Management principles and distributed leadership prove to be vital factors. These results are in agreement with Liden et al (2009) Denis et al (2001) findings, which indicated distributed leadership is regarded significant in healthcare, specifically while change and improvement are required. Academics have concentrated on the collaboration of leadership with context (Liden et al., 2009).

According to these data, we can infer that in order to succeed in implementing the Quality Management System, the top management requires setting Contingency Management principles in perspective. Top management needs to evaluate internal and external conditions in order to customize quality management system. In additional, according to Vroom-Yetton (1998) analyzing the situation and evaluating the barriers of quality management based on contextual variables, leader can make a conclusion about which style best fits the situation. Contingency approach, which is also known as situational approach, is based on the principle of avoidance from absolute principles. These results are consistent with those of Fiedler (1977) and Lawrence and Lorsch (1986) who established the significance of situation to the enactment of leadership.

Finally, the results showed that the complexity of hospitals makes the reliance on one leader in vertical leadership role unfeasible, meaning that multiple formal and informal leaders at different hierarchical levels drive organizational vision and change. This emergent, distributed leadership subsequently encourage adaptive change, organizational innovation and increasing organizational performance in the line of implementation of quality management system.

The results indicated that Quality Management System is a comprehensive process that can be practiced successfully. Quality management is not an issue that can be institutionalized alone or by one sector. Consequently, there is a need for public cooperation in this field. Overall, these results also indicate that to move in line with the standards of Quality Management System, Contingency theory principles and distributed leadership should be included as vital factors.

7.2.3.The Similarities and Differences between Private and Public Hospitals

Returning to the research question of *"What are the similarities and differences between quality management in Iranian hospitals?"* this section will now offer insights into this question.

The results showed that there are significant differences between public and private hospitals in line with quality management system and even in line with other issues of the hospital. These results are consistent with those of Teece, (2003) and Von Nordenflycht,

(2010) who suggest that both public and private sector professional service organizations have different governance and ownership. Though both private and public sector face similar issues in the nature of their principal tasks (Teece, 2003), these results are in agreement with Osborne's (2006) findings, which showed there are fundamental differences between the public and private sectors; hence comparisons between the two sectors are of little value. In this regard, maybe the most important difference is in the field of customer satisfaction and customer-oriented look in private hospitals in comparison with public hospitals, since the private section considered the customer satisfaction on the top of its strategies and goals in order to take some steps to get competitive advantage and continue its activities with better effectiveness and performance.

Most interviewees from top manager and middle manager levels of four case studies also mentioned that the core approach emphasizes fundamental differences between public and private hospitals, with the main distinction being their ownership. These results are in line with those of previous studies. In Rainey et al., (1976) the main conventional distinction between public and private organizations is their ownership. Whereas shareholders own private organizations, government owns public organizations. Prior studies have noted the differences between private and public organizations. Quantitative research has uncovered differences between private and public organizations on human resource management practices and policies (Boyne, 2000), management of ethical issues and decision processes (Nutt, 2000), whereas qualitative research has found differences in strategic management styles (Boyne, 2002).

Moreover, this research has identified that the private section has the best performance regarding customer satisfaction, which is noticeable in job satisfaction in public section. One of the most agreeable results in the job satisfaction literature is that the influence of job security on job satisfaction is important and great. According to Oswald, (1999) Job satisfaction developing from job security is a main element affecting the quality of the employer-employee communication. The most interesting finding was that the reverse relation between the job security and personnel communication with patients. Therefore, it was clear that in public sector because of the job security, which the personnel enjoyed, they didn't establish a good relation with the patients while in private section it was the contrary. Unfortunately, Iranian public health sector does not have a customer-oriented vision to the patient and this makes relation with patients weaker, which provides less satisfaction in patients.

The other results investigated among the issues in line with managing the hospital (treatment) centers are the way of selecting the chairman of the hospital, being different in private and public system. In public sector, there is a process to choose the hospital president, who is directed from out of the hospital. Therefore, there is no reference to a predetermined organized and logical process for selecting a hospital leader. In other words, the Head Medical Science University is a qualified figure in electing the chairman of the public hospital. Since the Medical University monitors the public sector directly, the public hospitals cannot act autonomously. Whereas, this process in the private sector faces a better process since the management assembly (broad direction), composed of the

shareholders, and chooses the president. In the private sector, the chairman and the top managers have more and better capabilities because they are chosen based on qualifications and requirements, and not based on the hierarchy structure found in the public sector. Consequently, the key finding was the freedom of the private sector in decision-making in line with selecting hospital chairman, organizational goals and programs. This freedom of action is due to familiarity with organization issues and comprehensive knowledge in existing potentialities. It is also based on the fact that it is more consistent with hospital's conditions and atmosphere.

The current study found that another difference between the private and government sector was that the private sector acted more customer-oriented and put more emphasis on effective management. Investigation in private and public sectors of professional service institutes indicates that leadership in those contexts has distinctive characters. Public hospitals have diverse governance and ownership constructions diverse from private hospitals. According to Greenwood et al. (1990), Teece (2003), and VonNordenflycht (2010) public hospitals have different governance and ownership structures from private firms.

The most significant difference emerging from the analysis is that in public sector centralized organizational structure is mechanistic whereas in the private sector the structure is more organic. Consequently, the organic structure of the private hospitals results in more effective conduction of QM. While the mechanistic structure creates a structure of accountability and focuses on unity of leadership, and forming a uniform

structure in the organization, yet it leads to some problems in implementation of QM (such as lack of employee involvement and hierarchical communication).

This difference in Tehran and Kermanshah is also being investigated regarding the tangible gap in line with equipment and facilities and access to information and financial resources. Since being far from the capital city has created restrictions in this case (Kermanshah). Comparing the ideas in Iran quality management system, as a developing country, with European developed countries showed that there are differences regarding specialists who apply the quality management system, objectivity, technology, and management.

As the final statement of the present argument and as the final comparison between the private and the public sectors, it can be argued that in spite of the panoptic position of the Ministry of Science as the external organization that sets the policies of Quality System Management, there are dramatic differences between the two sectors. Apart from the beautiful architecture, the warm, friendly and “hotel- like” atmosphere and the kind treatment of all the employees from the doorman to the crew of the private hospitals, when a patient is admitted to the hospital, s/he is overwhelmed by a wave of attention and the prompt service of the medical staff. On the contrary, in the public hospitals there is a harsh environment, and the medical staff looks angry and exhausted of. On the other hand, these dramatic discrepancies point out to the contrast in the nature of these two types of hospitals. To name a few are differences in equipment, differentiation in assessment, different relations between the patients and physicians and staffs,

differentiation in guidelines and protocols governing hospitals and educational characteristic of public hospitals. Finally, another significant difference observed was the participative decision-making in private sector as opposed to the Authoritarian decision making process in public sector.

7.3. Evaluation of Contingency Theory

Based on the discussion above about the differences and similarities of private and public hospitals in Tehran (developed city) and Kermanshah (developing city), it can be realized that although each situation may have its unique contextual variables, there are still similarities between situations. This is the same when considering implementing quality management in different hospitals and cities in one country; even though they are unique (although the type of quality management system which is introduced by the Ministry of Health is the same across the country), they have differences in different aspects. This is how organizational learning – one of the main concepts of contingency theory – can be effective; utilizing the past experiences from similar situations and applying them to the current situation. Therefore, the criticism of contingency theory by Hahn (2007) about negating the value of prior knowledge can be rejected. He has said that since the logic of this theory is uniqueness of each situation, it means that intuition and judgment are the only tools available for management; hence, the value of previous knowledge is denied.

The criticism is contradictory in itself, how can the top management be practiced by 'judgment' without prior knowledge and experience? Moreover, the theory is not

ignoring the similarities between different situations; it is just emphasizing on the uniqueness of each in order to justify why the decisions may differ in each situation. If each quality management system (QMSs) is totally different, learning cannot be taken from one QMSs to another. Therefore, it is based on the experience, knowledge, and available information about the new type of quality management system that one can make decisions on developing appropriate and effective strategies for managing the implementation of quality management.

Referring to the last sentence of the above paragraph, a word such as ‘appropriate’ has been critiqued and authors such as Galbraith (1973) and Schoonhoven (1981) have criticized the theory on the ground that it lacks clarity due to ambiguity of such theoretical statements. They have mentioned an example from Thompson- a contingency theorist- (1967) where he has suggested that a particular structure should be ‘appropriate for’ a given environment. This lack of clarity has been further criticized by other contingency theorists asserting that because of these ambiguities, people may perceive various meanings while studying this theory.

Even though these critiques can be considered as true, while discussing these and other critiques related to philosophical concepts and linguistics studies, attention should be drawn to two points:

- Usually when statements such as ‘appropriate’ or ‘consistent’ are used in scientific themes and theories, they can become more precise and meaningful

based on the pattern of the sentence and their application in the sentence. For further clarification, it is good to consider the opinions pointed out in philosophical areas and linguistic studies concerning the concept of words. Ludwig Wittgenstein in his book – philosophical Investigations (1953) has argued that the function a word performs in the language constitutes its meaning, so the meaning of a word can be perceived according to its use in the language. Therefore, the ambiguity of a word is not inherent but rather depending on its use in a context, it may result in unclear understanding.

- Regarding the further critiques about different people analyzing various meanings from their one's word, it should be noted that discussing the Hermeneutics studies, these critiques are indicated in the philosophical and linguistic areas. Hermeneutics refers to the diverse interpretations of people from words and texts (Mallery et al., 1986). This discussion may happen not only for the mentioned words (i.e. appropriate) but also for the complete research where different people may analyze the whole concept of the research differently. Although this criticism can be presumed as true, considering the context of any research, its readers would interpret its statements fairly similar.

Therefore, it should be stated that such theoretical statements- in the structure of the text and context of the research – to a great extent transfer the clarity and meaning of the words and would have the same interpretations (meaning) for majority of the people studying it. So, when contingency theory suggests that the top management strategies should match the situation, by defining the situation, they can be realize how the

conditions match the objectives. Considering the contingency theory in the context of implementation of quality management, by identifying the contextual variables of the situation to which the theory is applied to, the appropriateness of quality management strategies for the situation would be greatly understood.

Looking at the contextual variables of Iran, the degree of predictability is very low. For example, environmental uncertainty (because of international sanction and current economic situation) makes it difficult for organizations to predict and respond to the future. Based on the time of the implementation of quality management system in hospital, and referring to the argument provided earlier in this chapter about contingency theory, quality management, performance and their relationship, it is seen that both internal fit with the organizational structure, organizational culture and human resource and external fit with the environment affect implementation of quality management.

According to Zhang at al., (2012) organizations need to understand how to implement QM to achieve the maximum benefit. Consequently, hospitals also need to identify how to implement quality management to achieve the maximum benefit. Taking one-size fits all approach to quality management may not lead to optimal outcomes (Sousa and Voss, 2001, 2008). Different hospitals may need different approaches to quality management. Foster (2006) and Sousa and Voss (2008) mention the significance of taking a contingency theory perspective when implementing quality management. They also raise doubt about the “universal validity” of quality management practices. This research draws on Foster (2006) theoretical model, using contingency theory as theoretical lens;

consequently, the implementation of quality management depends on organizational structure and environmental contextual factors. More detailed evaluation of the theory is discussed in the next section.

Using contingency theory for implementation quality management (making decisions) has been stated to be unique for each particular situation (hospital). Consequently, the 'situation' ought to be described in order to refer to a more specific concept. Therefore, meaning of situation, embracing its contextual variables such as culture, environment, and economic context can be illuminating while considering the theory. For example, while discussing contingency theory in context of implementation of quality management in this research study, the situation can be more particular by pointing to its contextual variable i.e. economic, cultural, political and legal context. Though this does not mean that by defining the contextual variables, one specific quality management could be implemented for all the hospitals (either public/private) which were included in this research study; however, rather more similarities need to be clarified (for practicing the similarities among the dissimilarities). Although the hospitals can be more similar to each other comparing to public/private hospitals in another country, still each hospital is different from the other to some extent. Consequently, definition of the situation is required to be more specific, including the overall context (i.e. implementation of quality management), and the contextual variables. This research study further supports the idea of the universal vs. context-dependent method to QM. Recently, several scholars have started to examine the context-dependent approach (Sila, 2007; Sousa and Voss, 2008). According to Sousa and Voss (2008) who raises doubts about the 'universal validity' of

implementation of QM and suggests more investigation be done to understand to what contextual factors affect QM practices.

This research study supports a context-dependent approach and recognizes contextual factors that affect diverse kinds of quality management practices. This may ultimately lead to a more specific and described theory for any situation, and thus instead of stating *'it all depends"*, it can be stated as "it depends on internal and external factors, i.e. employing contingency theory for implementing quality management in Iranian hospital (public and private) depends on many variables of the country such as culture, economy, environment, and structural organization.

Contingency theory offers a theoretical lens to explain how organizations can customize quality practices. These results are further supported by Amundson, (1998) and Sitkin et al., (1994). Drawing on contingency theory, this study suggests that Iranian hospitals need to customize quality management practices in order to be successful in the process of implementation of quality management instead of adapted standardized approaches to QM. Consequently, the success of implementation of quality management practices depends on internal and external factors. This research establishes the importance of both internal and external fit, which provides useful insight for practitioners on how to implement quality management practices in Iranian hospitals. In the dynamic environment of Iran, both internal and external fit affect performance, which make effective implementation of quality management more complicated. Instead of supporting the traditional belief that all quality practices provide a "*universal remedy*",

this research supports the contingency view of the relationship between quality management practices and performance. Consequently, the effectiveness of implementation of quality management practices depends on both external and internal factors.

This research also establishes the importance of both internal and external fit, which provides useful insight for practitioners on how to implement quality management practices. According to the literature review, in a dynamic environment both internal and external fit affects performance (Siggelkow, 2001), which makes effective implementation of QM in this setting more complex (Rivkin and Siggelkow, 2007). This research supports the contingency view of the relationship between quality management practices and performance, instead of the traditional belief that all quality practices provide a *"universal remedy."*

Contingency theory suggests that successful organizations choose structures and process characteristics that *''fit''* the degree of uncertainty in their environment (Duncan, 1972). Contingency factors that may affect the establishment of this fit include internal and external factors.

This study also has suggestions for further research on how organizations may need to adapt their quality systems over time. For instance, organizations may need to change their focus on quality management with changes in the environmental contingencies. The quality system that made an organization successful today may not be the same system

that will make it successful in the future. Using the framework proposed in this research could reveal the challenges in reorienting the organization's quality system as the context changes. The research could possibly provide insight into how organizations may need to adapt their quality system over time to sustain high levels of quality performance.

Structural contingency theory is an extension of contingency theory and attempts to explain context– structure–performance relationships (Melan, 1998). The theory suggests that organizations that can establish a fit between organizational structure and environmental uncertainty will achieve higher organizational performance results (Schlevogt and Donaldson, 1999; Ellis et al., 2002), while a misfit would have a negative effect on organizational performance (Donaldson, 2001). Contingency theory suggests that successful organizations choose structures and process characteristics that ''fit'' to the degree of uncertainty in their environment. These results are further supported by Duncan (1972) and Miller, (1992). Contingency factors that may affect the establishment of this fit include both internal and external factors.

In general, therefore, it seems that the impact of quality management on health service performance varies across the different levels of environmental uncertainty. These results further support the idea of the influence of environmental uncertainty and organizational structure on the effectiveness of quality management. However, the structure of an organization is not independent from the environment that an organization is facing. Burton et al. (2002) develop a multi-contingency framework to understand how different factors affect performance (Burton et al., 2002). Siggelkow (2001) argues for two types

of fit: internal fit between the practices and the structure, and the external fit with the environment. Organizations that achieve both high internal and external fit should have higher performance than those that do not achieve both types. This study argues that organizational structure strongly influences the effectiveness of quality management. These results also are in agreement with Sila's (2007) findings, which showed QM practices benefit from an organizational structure which balances the need for control with the flexibility needed to respond quickly to the changing market. Furthermore, Douglas and Judge (2001) suggest that organizational structure moderates the relationship between QM and performance. This study argues that organizational structure influences the effectiveness of quality management. The current study has identified that environmental uncertainty influences the implementation of quality management (Benson et al., 1991; Sitkin et al., 1994; Nair, 2006), (Sila, 2007; Sousa and Voss, 2002). These results further support 'environmental uncertainty', which means that it is difficult to predict one does not lead to another, since lack of predictability is implied by 'uncertainty'.

These results further support the idea of Dale et al. (2007) who believes there is no best way to implement quality management, since no organization looks the same or has the same point of departure when implementing a quality management system. To better fit the specific context and organization, implementation procedure requires to be customized. Each hospital is unique, for instance in structure, objectives, organizational structure and organizational culture, etc., which means that there is no universal approach for implementation of quality management.

The emphasis of this research study is implementing quality management in hospitals and stating that due to one-off nature of the hospitals, there is no best approach to implement and manage them. Consequently, selecting contingency theory can be studied as a suitable theoretical framework for this research study as the core idea of this theory is in common with the emphasis of this research study. The contingency theory rejects the concept that there is one best approach to implement and manage quality.

However, Drazin and Van de Ven (1985) criticized the concept of contingency theory, in which organizational fitting is studied as the theory whose success depends on the situation. Contingency theory typically considers the range of propositions that are not straightforward generalizations about implementation procedure in an institute. For instance, in developing nations, the introduction of QM lags behind the situation in advanced countries, and consequently QM can be taken into account as a 'newly introduced management technology'. As van Harten et al., (2002), in the introduction of this new philosophy showed there are two suitable reflections:

- The progressive stages lead to the conclusion that there is no well-defined QM approach that fits each type of organization
- The proposal of the QMS will be dependent on the pre-existing contexts

Implementation of quality management is frequently targeted by successful practices in an organization in one special country. *"It worked in Japan so why does it not work here?"* This has been a common expression whenever an association directly attempts to

implement an idea concerning quality or process management from Japan. The requirement to perceive quality management from a context standpoint needs admitting the context dissimilarities. Deming (1993), for instance, extended a theory of management acknowledged as *"a system of thoughtful (profound) knowledge"* that is appropriate to any culture. Deming remarks that the application of this theory in a society will be liable to be restricted to issues exclusive to the context of this society. In other word, it means that focusing on specific features of a country is inescapable though there is no commonly acknowledged characteristic of context, which fits all organizations.

It can thus be suggested that the level of differences and similarities between private/ public, Kermanshah and Tehran should be expected in the context of quality management system. The contingency theory is appropriate for this context; the quality management system should be customized since there are public/ private divide and regional differences. The appropriate quality management is needed in each hospital since each one is in a different context when region and public/private sectors are taken into account.

In general, therefore, it seems that among the features of quality management content, the role of hospital leadership is vital in implementation of quality management. In initiating the implementation, the leadership of a hospital is expected to open up awareness in grasping the internal and external conditions, and filter them to frame the requirements of the organization. Based on the specific background, in managing the implementation, the leader holds specific rationales for success. The needed

competencies not only cover managerial knowledge on quality management content, but also awareness of context and culture.

From the previous review, it can be seen that the findings differ in perspectives and views about the role of top management leadership within Iranian private and public hospitals. Though majority results consistently assert the vital and critical role of top management in implementing quality management system, it is hard to investigate from the literature and this research findings how this role is significant and how it is related to other quality management practices.

In order to justify fitting the contingency theory model to this current study, the table is designed.

Table 7.1: Implementation of Quality Management System

	Kermanshah (Developing City)	**Tehran** (Developed City)
Public	**(Accreditation + Government Inspections)** ^{X}	**(Accreditation + Government Inspections)** ^{XN}
Private	**(Accreditation + Customer Satisfaction)** ^{X}	**(Accreditation + Customer Satisfaction)** ^{Xn}

X refers to the combination of human resource, finance, and physical resource, facilities committed to QM

N or n refers to a multiplier greater than zero, indicating the level of increased resources (Human, finance, physical resource, facilities) available.

Table 7.1: Table made by Author

This table indicates (table 7.1) that QMS (Accreditation) is common with all hospitals (private and public sectors in Kermanshah and Tehran). However, there is a gap between the private and public hospitals in the line of quality management system implementation. Customer satisfaction is significant in private sector whereas government inspection is important in public sector. In addition, this table shows that the power of the QM (Accreditation) is greater in Tehran (both private and public hospitals) than Kermanshah because of the greater human, financial, and physical resources and facilities (hence QM^{X+Ns}) that can explain the higher rating in audits that are part of accreditations process. Therefore, regarding the regional differences, QMS X should be customized according to Contextual Factors such as cultural, political, and economic condition since each condition would affect implementation of quality management differently. Consequently, customization of QMSs is needed in hospitals since each is in a different context when region and public/private are taken into account. However, this research does not provide any information about the influence degree of each of these factors.

This present study favours distributed leadership in all cases. However, the distributed leadership may be better able to customize QMS. Consequently, the situations will create dissimilar leadership theory requirements for a leader. The solution to a managerial condition is contingent on the factors that affect the situation (internal and external factors). Based on Fiedler's contingency theory, the hospital leaders would respond differently to different specific contexts in line with quality management system

implementation. For instance, in a highly routine (mechanistic) environment where repetitive tasks are the norm, a relatively directive leadership style may result in the best performance; however, in a dynamic environment a more flexible, participative style may be required. However, this research study suggests that in hospital environment, distributed leadership would be appropriate since everybody should be involved in the process of quality management system implementation.

As a conclusion to the argument, and in order to succeed in actualizing the Quality Management System, the hospital top management requires to set Contingency Management principles in perspective. Contingency approach, which is also known as situational approach, is based on the principle of avoidance from absolute principles. In fact, the necessity of Contingent Management is based on the principle that the performance of the manager, at any time, should be evaluated based on the *"status and condition of his/her activity."* Therefore, the focus in this approach is on the coordination between management responses on the one hand, and unique issues and opportunities on the other hand. As a result, based on the situational and environmental factors, the manager attempts to develop the principles of Quality Management System in the hospital. Based on this principle and in the context of contingency management, the manager is required to transform his authority from management to leadership. In addition, in the context of divided leadership and based on the statements of the interviewees, the manager can perform effective implementations. The manager is required to move in line with Quality Management System by assigning responsibilities to various institutional groups. S/he also needs to be aware of the fact that all institutional

groups are set and act based on common values, cultures, symbols, and traditions. Somehow, the manager can move towards divided leadership by taking measures like cooperation and harmony, freedom of expression and insight and purposeful division of duties. This can also be implemented due to the expertise and participation in organizational duties and other professional tasks, participation in organizational decisions and professional assignments. As a conclusion, it can be argued that by benefitting from Contingency approach and using divided leadership style, a significant role can be played to improve the system of Quality Management.

7.5. Chapter Summary

From the previous review, it can be seen that the findings differ in perspectives and views to implementation of quality management system and the role of top management leadership within both private and public Iranian hospitals. However, majority results, consistently asserts the vitality and criticality role of top management in implementing quality management system. Though it is hard to investigate how this role is significant and how it is related to other quality management practices from the literature review and the findings of this present study. However, the complexity of hospitals makes the reliance on one leader in vertical leadership role unfeasible, meaning that multiple formal and informal leaders at different hierarchical levels drive organizational vision and change. This emergent, distributed leadership subsequently encourage adaptive change, organizational innovation and increasing organizational performance. The current research study identified that Quality Management System is a comprehensive process that can be practiced successfully. Quality management is not an issue that can be

institutionalized alone or by one sector. Consequently, there is a need for public cooperation in this field. Overall, Contingency theory principles and distributed leadership should be included as vital factors in the line of implementation of quality management.

This chapter discussed the empirical findings of the four case studies and links these with the findings of the literature review. The field study results are thus reviewed in the context of previous findings and theoretical explanations in order to draw both practical and research implications. The basis of the discussion was the similarities and differences between findings identified in the literature review and the corresponding findings of the case studies. In relating the findings to the previously reviewed literature, a better understanding is gained of the similarities and differences between hospitals in Iran, as represented by the case studies, and hospitals. It is finally continued with evaluation of the contingency theory (the theoretical framework of this thesis) in the context of quality management implementation. Consequently, this chapter answers the research questions, proposes guidelines, which may be effective for other countries with similar situation and continues with discussing the results in relation to contingency theory.

8.0. Introduction

This research study has studied quality management system implementation in four hospitals in Iran. It aimed at examining the Implementation of quality management systems in Iranian private and public hospitals with particular emphasis on the role of Leadership. The research method adopted was based on the phenomenological philosophy, utilizing a case study research design. The needed data were gathered in two major steps. The first step was the secondary data collection technique, a widespread literature review to comprehend the appropriate characteristics of implementation of quality management, in addition to identifying the role of hospital leadership in the process of implementation. The second step was gathering primary data by in-depth, semi-structured interviews in four case studies (public and private hospitals), added by a review of archival documents.

The analysis and discussion of the data collected were carried out to investigate and interpret the participants' responses and their implications in order to identify and understand the role of hospital leadership in implementing quality management in private and public hospitals. This research study offered valuable results to both hospital leadership and quality management in health care and differences and similarities between private and public hospitals.

The theoretical framework for this research study, as a structure for supporting the research work, was selected to be contingency theory to clarify why the problem under study exists and to stand as a foundation for conducting the investigation. To examine how implementing quality management can be managed properly depending on the environment, data collection methods were used and top manager and middle manager involved in implementation of quality management were chosen as participants. The selected hospitals for the thesis were private and public ones. Interviews were conducted in order to obtain the knowledge and comprehend how these participants identify the role of hospital leadership in implementation of quality management process.

8.1. Meeting the Aim and Objectives of the Research

Based on the analyses, as presented and discussed in chapter six and seven, the subsequent summary of the key findings and conclusions were derived. In order to make them well defined, they are divided into the three objectives.

8.1.1 Conclusion of Objective One

The fist objective of this research study is to investigate the current types of quality management systems which Iranian hospitals use in private and public hospitals (Kermanshah and Tehran cities).

This study has shown that over the years, the quality management systems in the Iranian hospitals have been on an increasing trend. Based on interviews conducted,

quality management system that is currently in use in Iran's health centers is a part of accreditation-integrated model in all parts of the country being mandated by the Science Ministry to Medical Science Universities. The quality management has brought about positive changes such as improving the hospital work procedures and services quality, presenting a feedback to management about quality management system, and attempting to achieve maximum standards in the Iranian hospitals. However, the hospital is still facing problems in the implementation of quality management system. This is because of non-localization of quality management system and lack of coordination in the situation, lack of possibility to change the accreditation plan (QM) by each hospital, and the inability of current quality management to cover all plans and activities. The other results of this research focused on the centralized and hierarchical (pyramidal) organizational structure of medical centers in a way that the decision are taken and programs are panned in the top of the pyramid. Based on empirical findings, in all cases there is centralized decision-making, with the Ministry of Health dictating that there must be a hierarchical structure. The results of this research indicate that QMS (Accreditation) is common to all hospitals (private and public sectors). However, there is a gap between the private and public hospitals about quality management system implementation which will be discussed more comprehensively in the section (8.1.3) Customer satisfaction is significant in private sector whereas government inspection is important in public sector. This research study has also identified that the power of the QM (Accreditation) is greater in Tehran compared with Kermanshah because of the greater human and financial resources of hospitals (hence QM^{x+n}). In other words, there are more resources (human, finance, physical, facilities) in both public and private hospitals of Tehran compared with

those of Kermanshah that can explain the higher ratings in audits are part of accreditations process (refer to table: 8.1).

- **Implementation of Quality Management System**

	Kermanshah (Developing City)	**Tehran** (Developed City)
Public	**(Accreditation + Government Inspections)** ^{X}	**(Accreditation + Government Inspections)** ^{XN}
Private	**(Accreditation + Customer Satisfaction)** ^{X}	**(Accreditation + Customer Satisfaction)** ^{Xn}

X refers to the combination of human resource, finance, and physical resource, facilities committed to QM

N or n refers to a multiplier greater than zero, indicating the level of increased resources (Human, finance, physical resource, facilities) available.

Table 8.1: Table made by Author

Another objective was to identify the factors affecting the process of implementing quality management in Iranian hospitals. This study has divided the factors affecting quality management into internal and external factors, which affect the process of implementing quality management system in Iranian hospitals. The results of this investigation show that regarding the external factors, hospitals are facing social, political and economic restrictions and in a broader view the equipment and drugs shortages, distance from the center and in the more and macro view the economic sanctions as

external factors are introduced as limiting agents of quality management system. The research has also identified that organizational culture, organizational structure, and leadership involvement and commitment as internal factors effecting implementation of quality management system. It is worth to point out that some interviewees consider the affecting factors in implementation of quality management as barriers to quality management system.

Furthermore, this research study has identified some barriers to quality management system implementation, such as organizational structure, organizational management, financial problem, centralized system, inadequate education, organizational inflexible atmosphere and culture, lack of precise evaluation, resisting toward change, time, lack of motivation in employee, lack of awareness of top management about benefits of quality management, lack of QMS understanding in the hospital, lack of decentralization, lack of enough relationship between management department and other sections that can limit the effective and suitable quality management system and more important than all the managers' beliefs.

Consequently, the types of quality management system and their performance in those hospitals, the internal and external factors, which effect implementation of quality management, and the barriers to quality management system implementation were identified, investigated, and analyzed. Ultimately, this research study recognized the main barriers to successful implementation of quality management system for Iranian hospitals context.

8.1.2. The Conclusion of Objective Two

The second objective of this research were to investigate the role of hospital leadership in implementation of quality management in private and public hospitals and determine the pattern of leadership in leading quality management in context of hospital, and examine the relationship between leadership, doctors (professional) and government. To meet these objectives, this research study has defined Leadership in order to deeply understand the role of hospital leadership in implementation of quality management. This research study has identified that there are trends towards participative management in the public and private hospitals. Although, this research realized that the participative management seems in progress, however, the final decision maker is the hospital leader. In fact in this case, top management can't realize the advantages of sharing power or distributing it from upper level to subordinates and lower staff. This has the best participative management but not a case of distributed leadership. This research study has identified the patterns of leadership, which are in use in private and public sectors in Kermanshah and Tehran. Based on the findings, in Kermanshah the patterns of leadership in private sectors were both participative and somewhat authoritarian whereas, it was authoritarian in public sectors both in both cities (Kermanshah and Tehran) in which the final decision-maker is the top management. Furthermore, the patterns of leadership in use in Kermanshah and Tehran were Participative or Authoritarian (refer to table: 8.2). Moreover, this study also identified the patterns of organizational structure in Kermanshah and Tehran. The pattern of organizations in use in Kermanshah is

mechanistic structure, whereas in Tehran it is somewhat organic structure (refer to table: 8:3).

- **Summarizing Leadership Patterns**

	Kermanshah (Developing City)	**Tehran** (Developed City)
Public	**Authoritarian**	**Authoritarian**
Private	**Slightly Participative or Somewhat Authoritarian**	**Participative**

Table 8.2: Table made by Author

- **Summarizing Patterns of Organizations**

	Kermanshah (Developing City)	**Tehran** (Developed City)
Public	**Mechanistic**	**Mechanistic**
Private	**Somewhat Organic**	**Somewhat Organic**

Table 8.3: Table made by Author

Another objective was to identify the relationship between leaders, doctors (professional) and government in private and public hospitals in terms of power

proportion. This pyramid in the private and public sector has power in different proportion of services centers. The significant differences of private and public sectors are that in private sector the managers are on top of strategic pyramid while in public sector government and specialists had more powerful dimension in the trifocal pyramid. Naturally, the public centers are more affected by the government regarding the state budget and sponsorship. In contrast, the medical specialists in private sector have more power regarding their strategic role and hospital's needs. A notable point about specialists and their power is the existence of conflict with managers' strategy, whose root can be traced in doctors and management's one-dimensional look to hospital and paying attention to individual rather than organizational goals. Managers' weak interaction and lack of effective communication between managers and physicians are also seen in both groups' performance and plans.

The main goal of the current study was to determine the role (effective approach) of top management in the context of Quality Management System. To do so, the researcher also conducted interview. Based on empirical findings, this research study has identified and discussed the theory that division of power among members of the organization is an effective approach in the context of implementation of quality management. Therefore, everyone can put forward his/her opinion in line with organizational activities, and all the employees should consider themselves as a level of managing quality system. In addition, based on empirical findings, this study has identified that the top management could not control the employees through policies, procedures, and monitoring. Consequently, the leaders are required to be willing to share power their roles as leaders so that they can

have an effective management in line with the implementation of Quality Management System. The complexity of hospitals makes the reliance on one leader in vertical leadership role unfeasible, meaning that multiple formal and informal leaders at different hierarchical levels drive organizational vision and change. This emergent, distributed leadership subsequently encourage adaptive change, organizational innovation and increasing organizational performance. Overall, these results indicate that to move in line with the standards of Quality Management System, Contingency theory principles and distributed leadership should be included as vital factors. Finally, the results showed that the complexity of hospitals makes the reliance on one leader in vertical leadership role unfeasible, meaning that multiple formal and informal leaders at different hierarchical levels drive organizational vision and change. This emergent, distributed leadership subsequently encourage adaptive change, organizational innovation and increasing organizational performance.

The current research study identified that Quality Management System is a comprehensive process that can be practiced successfully. Quality management is not an issue that can be institutionalized alone or by one sector. Consequently, there is a need for public cooperation in this field.

8.1.3. Conclusion of Objective Three

The third objective was to find similarities and differences between private and public Iranian hospitals in terms of their quality management systems (the effecting factors in implementation process and also barriers of implementation process) and compare different cities, namely, a developed city and a less developed one (Tehran and

Kermanshah). To do this, the researcher classified the similarities and differences into different categories. The literature review has mentioned that there are some differences and similarities between private and public sectors and this analysis to the case support this view. The distinction made between private and public sectors here, was also common to the literature review and the case studies on one hand, yet some distinctions were found to be unique to the present study, as discussed in discussion chapter 7. The results showed that there are significant differences between public and private hospitals in line with quality management system and even in line with other issues of the hospital. Public hospitals have dissimilar governance and ownership constructions different from private organizations. However, both private and public sector face similar issues in relation to the nature of their principal tasks such as implementation of quality management system. This study has identified that the most important difference is in the field of customer satisfaction and customer-oriented look in private hospitals as opposed to public hospitals. The private section considered customer satisfaction on the top of its strategies in order to take some steps to get competitive advantage and continue its activities with better effectiveness and performance. While, in public hospitals the emphasis is on working procedures (work-oriented approach). In addition, private hospitals emphasized more on effective management in comparison to the public sector. This research has also identified that the private section had better performance regarding customer satisfaction, while job security was more ostensible in the public section. The fundamental difference between public and private hospitals was their ownership. Although shareholders own private organizations, government own public organizations.

The key similarity between public and private hospitals is that there is an official form as hospital official plan, in which all wards and sections are obliged to keep and observe harmonized plans. Before being ordered by the Health Ministry, hospitals (private/public) already had some plans and operated some quality systems, but in current years the Clinical Governance and Accreditation have been mandated by the Health Ministry and all hospitals must follow them in their hospitals. Clinical Governance and Accreditation are unchangeable systems based on which the hospitals are evaluated. In additional, every plan mandated to the hospitals by the Ministry of Health about quality management system does not consider general, social, cultural, economic, and geographical conditions. In addition, the quality management system modeling has been copied from developed countries such as USA and European countries without customizing (localizing) it and to be coordinated with every country's political, economic, and cultural conditions.

Furthermore, the difference between private and public sectors in line with managing the hospital (treatment) centers is the way the head of hospital is selected. In the public system the leader of the hospital is selected externally here favoritism and lack of codified law in line with the selection of most qualified person has created more significant problems, whereas this process in the private sector faces a better process since the management assembly (broad of directors), who are the shareholders, choose the chairman.

This research has also identified that the private section had better performance regarding customer satisfaction, while job security was more ostensible in the public

section. Another difference seen in both private sector and government sector was that the private sector acted more customer-oriented. In comparison with public sector, the private sector emphasized more on effective management.

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In addition, it can be argued that in spite of the panoptic position of the Ministry of Science as the external organization that sets the policies of Quality System Management, there are dramatic differences between the two sectors. Apart from the beautiful architecture, the warm, friendly and “hotel- like” atmosphere and the kind treatment of all the employees from the doorman to the crew of the private hospitals, when a patient is admitted to the hospital, s/he is overwhelmed by a wave of attention and the prompt service of the medical staff. This is in dire contrast with the harsh environment; the angry and exhausted looks of the medical staff of the public hospitals. On the other hand, these dramatic discrepancies point out to the contrast in the nature of these two types of hospitals. To name a few are differences in equipment, difference in guidelines and protocols governing hospitals, and educational characteristics of public hospitals.

This study also has argued that, Tehran and Kermanshah are being investigated regarding the tangible gap in equipment, facilities and access to information and financial sources. Being far from the capital city has created restrictions for Kermanshah city. There are more resources (human, finance, and physical resource, as well as facilities) in Tehran in both public and private hospital compared with Kermanshah, which justifies the higher ratings in audits. Comparing the ideas in Iran quality management system, as a developing country, with those of European developed countries showed that there are differences regarding specialists who apply the quality management system. Objectivity, technology and management should be investigated with critical and hair-splitting looks. Overall, the similarity between Kermanshah and Tehran is in that each case Accreditation is based on QM. Secondly, there are differences between private and public sectors. In the private sector more emphasize is put on customer satisfaction, whereas in public sector there is more independent assessment of performance by government. Thirdly, there are more resources (human resource, finance, physical resource, as well as facilities) in Tehran in both public and private hospital compared with Kermanshah, which explains the higher ratings in audits.

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Finally, through discussion of the research findings, the overall research questions were answered, and thus the aim of this study, which was to investigate the implementation of quality management system process in private and public hospital with particular emphasis on the role of Leadership in the implementation of quality management in Iranian hospitals (public and private) materialized.

8.2. Research Framework

A pattern based on the research findings shows that QM and the factors affecting it are in the pivotal and balancing point of the hospital top management that is affected by the external and internal factors simultaneously. In the organization environment, the organizational culture provides a condition in which current plan and systems are advancing, in which organizational structure can provide some conditions that disturb the plan or Quality Management. One of the key factors in organization's internal factors is human force. In today's world every country's capability, economic power and welfare depend on optimum use of facilities, industries and human source. The more qualified and effective staffs are, the more progress and success a country will have in different social and economic areas.

The results of many studies and research about the role and importance of human resources in developing the organizations emphasizes that no society is developed unless it pays attention to developing the human resources. Nowadays, the scholars of human resources have found that skillful and qualified human resource is a valuable and an

indefinite capital to grow and develop the countries and organizations. It is also the main factor of every country's success. If in the past, land, capital and working were considered as manufacturing factors, nowadays the human resources, technological changes and increasing the productivity are considered as development and growth factors. The top management should be able to take some steps to advance the quality management system by establishing the supportive open culture and flexible organizational structure (organic structure) associated with human resources optimization and development. In contrast, the dominant economic, social and cultural situations out of the organization affect the management and quality management system. Looking open-mindedly and unbiased, one can say that the management cannot have very much power to change the dominant conditions of the organization. As a result, by taking a suitable approach (contingency theory), the manager should coordinate the outside conditions with the inside ones in order to allocate financial and information sources in line with his communicative role. The management' success in this system depends on taking necessity (contingency theory) approach. The leader should take suitable and corresponding action regarding the current conditions and situations so that while improving the organization's internal conditions and situations and coordinating the outside with inside, have a very effective role in quality management as well.

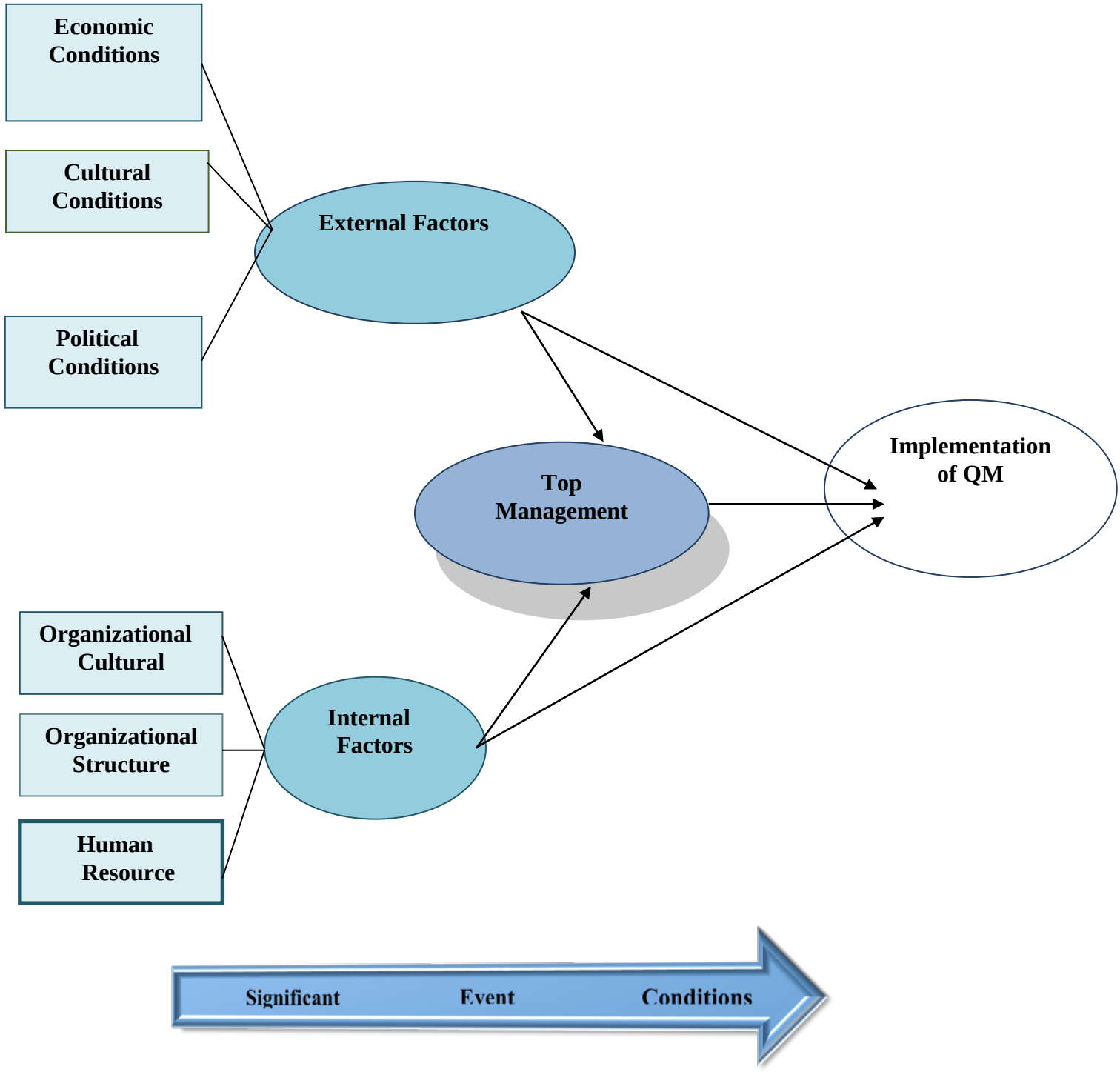

Figure 1: Diagram made by Author

8.3. Contribution to Knowledge

The particular aim of this research study as mentioned was to examine the implementation of quality management in Iranian hospitals with particular emphasis on the Role of Leadership. In addition, this research study investigated the types of quality management and evaluated their performance in Iranian hospitals. It is the first time that such a study been conducted in Iran. Actually, it became clear from the literature review that there was very slight evidence that dealt specifically with QM in a hospital context. Most of the literature focused on implementing quality systems such as ISO 9001 (2000) in the manufacturing sector when this study started. Consequently, the researcher decided to explore the role of hospital leadership in implementing quality management as a way of addressing an under-researched area.

The literature indicated that the key elements, which influence quality management implementation, are related to the involvement and commitment of top management awareness among managers. The current findings add to a growing body of literature on involvement and commitment of top management that the top management cannot only control the employees through policies, procedures, and monitoring. From the literature review and the finding of this research study, it can be seen that the findings differ in perspectives to the role of top management leadership and its commitment within service sector organizations particularly in Iranian hospitals. However, majority results unanimously state the vital and critical role of top management leadership and commitment in implementing quality management. Though it is hard to find strong argument in how this role is significant, the contribution of this study has been to confirm

that top managers are required to be willing to share power in their roles as leaders so that they can have an effective management in line with the policies of implementation of Quality Management.

Theoretically, the significance of quality management in practice and the need to expand knowledge in developing countries indicates that developing the present knowledge of QM literature in these nations is contributing. It is essential to mention that there is shortage of empirical studies of factors affecting the implementation of quality management in in hospitals also in different nations in general and in Middle East countries in particular. Consequently, this research study address this shortage of studies and provides further understanding of the operation of QM in a Middle East and specifically Iranian context.

Additionally, this research study identified some barriers that have not been reported in the literature review as applying to other countries. The barriers include implementation of quality management system time, and quick change of quality management system strategy. From the discussion of the findings, it was concluded that the frequent changes of quality management system strategy create problem for implementation. As stated in the discussion chapter, in a ten year period, 8 quality management systems were conducted in the in the private and public sectors of medical services. If there were a preplanned time for every project, naturally we could yield better (effective) results and fewer changes would occur in the quality management system. Furthermore, this research study identified one of the most significant barriers unique to

the Iranian environment. The quality management system is copied from America and Europe and is used and translated without harmony with the characteristics of the country. In other words, almost all interviewees point out that quality management system has been copied from developed countries without customizing (localizing) it and to coordinate with country's economic, political, social and cultural conditions. Therefore, based on contingency theory, scientific methods (such as QM) need to be customized according to Iran's conditions. The contribution of this study has been to confirm that the requirement to perceive quality management from a context standpoint needs one to admit the context dissimilarities. *"It worked in Japan so why not here?"* This has been an instance of common expression at whatever time an association attempts to directly implement an idea concerning quality management from Japan like quality control circles being highly effective in Japanese context. In other words, it means that concentration on specific features of a country is inescapable, though there is no commonly acknowledged characteristic of context being fit all. Finally, this research study recognized the main barriers to successful implementation of quality management system for Iranian hospitals context.

The literature review suggested that modern, pluralistic organizations could no longer rely on traditional models of leadership, instead requiring a more emergent and dynamic approach, such as the use of distributed leadership which encourage informal leadership at all hierarchical levels (Marion, 2001; Pearce 2007; and Desice 2007). In this way hospitals could encourage the development of networks, increased organizational commitment and innovation. Existing research into the distributed leadership suggests

that it rests on two significant requirements: first that distributed leadership is dependent on a strong supportive team and secondly that those in formal leadership positions will support informal leaders, moving the organization towards a flatter, network based structure rather than hierarchical one.

These findings enhance our understanding of Quality Management System is a comprehensive process that can be practiced successfully. Consequently, there is a need for public cooperation in this field. Overall, these results also indicate that to move in line with the standards of Quality Management System, Contingency theory principles and distributed leadership should be included as vital factors.

Furthermore, this research study affects the way of activities and thoughts in the context of quality management systems implementation in healthcare institutes. According to the above discussion and denoting the evaluation of the contingency theory in the context of quality management discussed in previous chapter, contributions to knowledge are provided: adapting the contingency theory from a conceptual theory to a more appropriate and meaningful theory. Thus, the research study makes the subsequent contributions:

- This is the first research study conducted about quality management system implementation in a developing nation, Iran. It utilizes Iran as a lens through which this phenomenon is studied. The review of the literature in the ground of implementing quality management system recognized gaps and the requirement

for more empirical research; thus, this research study extends and integrates the studies done in this ground. It has carried together a large body of knowledge in relative to quality management implementation in healthcare organizations in developing countries such as Iran.

- This study raises the awareness of the importance of quality management system programmes as imperative, philosophically and strategically, which could help hospitals to have a better understanding of how quality management system could be effectively implemented (refer to research framework). Particularly, this research study made an imperative contribution to health care sector by researching quality management system implementation model in Iranian hospitals (refer to the research framework).

- The main theoretical contribution of this thesis is an original contribution to the literature in integrating a contingency develop to quality management with an emphasis on distributed leadership as an approach to facilitating effective implementation of quality management in a hospital context. The findings of this thesis could be used to help health professionals and managers to implement quality management system more successfully Iranian hospitals by applying distributed leadership and analyzing the relevant internal and external contextual factors to inform decision making on how QM is to be implemented.

- This research study also supported the result of other investigators in the Middle East such as Zien Yusoff et al. (2012), Keng and Abdul-Rahman (2011), Ab

Wahid et al. (2011), Sharif (2005), and AI-Madi (2005) Flynn et al. (1994); Teh at al. (2009), and Ang et al, 2011) regarding the role of top management support as crucial to implementation of quality management.

- This research study is also valuable in that it has been capable to offer useful guidelines in the form of recognizing the barriers to implementation of quality management such as time, resistance to change, lack of awareness of top management, lack of decentralization, cultural issue, and implementation of quality management without customizing it. Finally, professionals could utilize these barriers as a direction while scheduling to implement quality management practices in their healthcare institutes. Professionals can gain better appreciation of the procedure of implementation and what they require to concentrate on in order to develop implementation.

- This research also answers the recommendations of scholars such as Mohammed (2005), Sharif (2005), and AI-Haj (2006), who have stressed need for more studies in the ground of quality management implementation in developing countries. This study has contributed to making up for this deficiency.

- This research supports the contingency view of quality management implementation success and empirically validates the moderating influence of internal and external contingency factors (economic, political, social, and cultural conditions as internal factors and organizational culture, organizational structure,

and human resource as external factors) on the relationship between quality management practices and performance. Based on the results of the current study, there are regional differences between four cases, QM X should be customized according to Contextual Factors such as cultural, political, and economical condition since each condition would affect implementation of quality management differently. Consequently, customization QM is needed in hospitals since each is in a different context when region and public/private are taken into account. However, this research does not provide any information about the degree of influence of each of these factors. Moreover, this research study determines the significance of internal and external fit, which offers helpful insight for experts on how to implement QM practices. In a dynamic situation (environment), internal and external fit impact performance (Siggelkow, 2001), which creates successful implementation of quality management in this setting more difficult (Rivkin and Siggelkow, 2007).

This study contributes to the discussion in the literature through the universal vs. context-dependent method to QM. Using contingency theory for implementation quality management (making decisions) has been stated to be unique for each particular situation (hospital). Consequently, the 'situation' ought to be described in order to refer to a more specific concept. Therefore, meaning of situation, embracing its contextual variables such as cultural, environmental, political, and economic contexts can disclose more points. For example, while discussing contingency theory in context of implementation of quality management in this research study, the situation can be more particular by pointing to its

contextual variable i.e. economic, cultural, and political-legal context. As mentioned before (Methodology chapter 5, and Discussion chapter 7) Iran has unstable economic and political conditions at the moment. Though this does not mean that by defining the contextual variables, one specific quality management could be implemented for all the hospitals in Iran (either public/private). A definition of the situation is required to be more specific, including the overall context (i.e. implementation of quality management), and the contextual variables. This research study supports the context-dependent method to QM. Recently, several scholars have started to examine the context-dependent approach (Sila, 2007; Sousa and Voss, 2008). Sousa and Voss (2008) raise doubts about the 'universal validity' of implementation of QM and suggest that more investigation ought to be done to analysis if QM practices are contextual factors or context dependent. This research study offers empirical evidence to support a context-dependent approach and recognizes contextual factors that influence diverse kinds of quality management practices.

This ultimately may lead to more particular and detailed theory for any condition, and thus instead of saying, *"it all depends"*, it can be specified that *'it depends on internal and external factors'*, i.e. employing contingency theory for implementing quality management in Iranian hospital (public and private) depends on many variables of the country such as cultural, economic conditions, and environmental and structural organizations. Using contingency theory for implementing quality management system in public sectors (Kermanshah and Tehran) depends more on economic and political conditions of the country than other variables. More than other variables, the private

sectors (Kermanshah and Tehran) depend on political conditions of the country. In additional, contingency theory offers a theoretical lens to explain how organizations can customize quality practices, which are further supported by Amundson (1998) and Sitkin et al. (1994). Drawing on contingency theory, this study suggests that Iranian hospitals need to customize quality practices in order to be successful in the process of implementation of quality management. Consequently, the success of implementation of quality management practices depends on internal and external factors.

The contribution of this study has been to confirm that in order to succeed in implementation of the Quality Management System, the hospitals' management requires setting Contingency Management principles in perspective. Contingency approach, also known as situational approach is based on the principle of avoidance from absolute principles. In fact, the necessity of Contingent Management is based on the principle that the performance of the leader, at any time, should be evaluated based on the *"status and condition of his/her activity."* Consequently, the focus in this approach is the coordination between management responses on the one hand, and unique issues and opportunities on the other hand. As a result, based on the situational and environmental factors, the leader attempts to develop the principles of Quality Management System in the hospital. This study has demonstrated, for the first time that based on these principles and in the context of contingency management, the leader is required to share his/her authority. In addition, based on the statements of the interviewees, top management can perform the implementations effectively using distributed leadership. The current findings add to a growing body of literature on quality management that the leader can

move towards distributed leadership by taking measures like cooperation and harmony, freedom of expression and insight and purposeful division of duties. This can also be implemented due to the expertise and participation in organizational duties and other professional tasks, participation in organizational decisions and professional assignments. The study has gone some way towards enhancing our understanding of benefits of Contingency theory. Through distributed leadership approach, a significant role can be played to implement Quality Management system (Figure: 8.3).

Finally, the present study favours distributed leadership in all cases. However, the distributed leadership may be better able to customize QMS. Consequently, situations will create dissimilar leadership theory requirements for a leader. The solution to a managerial condition is contingent on the factors affecting the situation (the internal and external factors). Based on Fiedler's contingency theory, the leaders of hospitals would respond differently to different specific contexts in the line of implementation of quality management system. For instance, in a highly routine (mechanistic) environment where repetitive tasks are the norm, a relatively directive leadership style may result in better performance; however, in a dynamic environment a more flexible, participative style may be required. This research study suggests that in hospital environment, distributed leadership would be appropriate since everybody should be involved in the process of implementing quality management system.

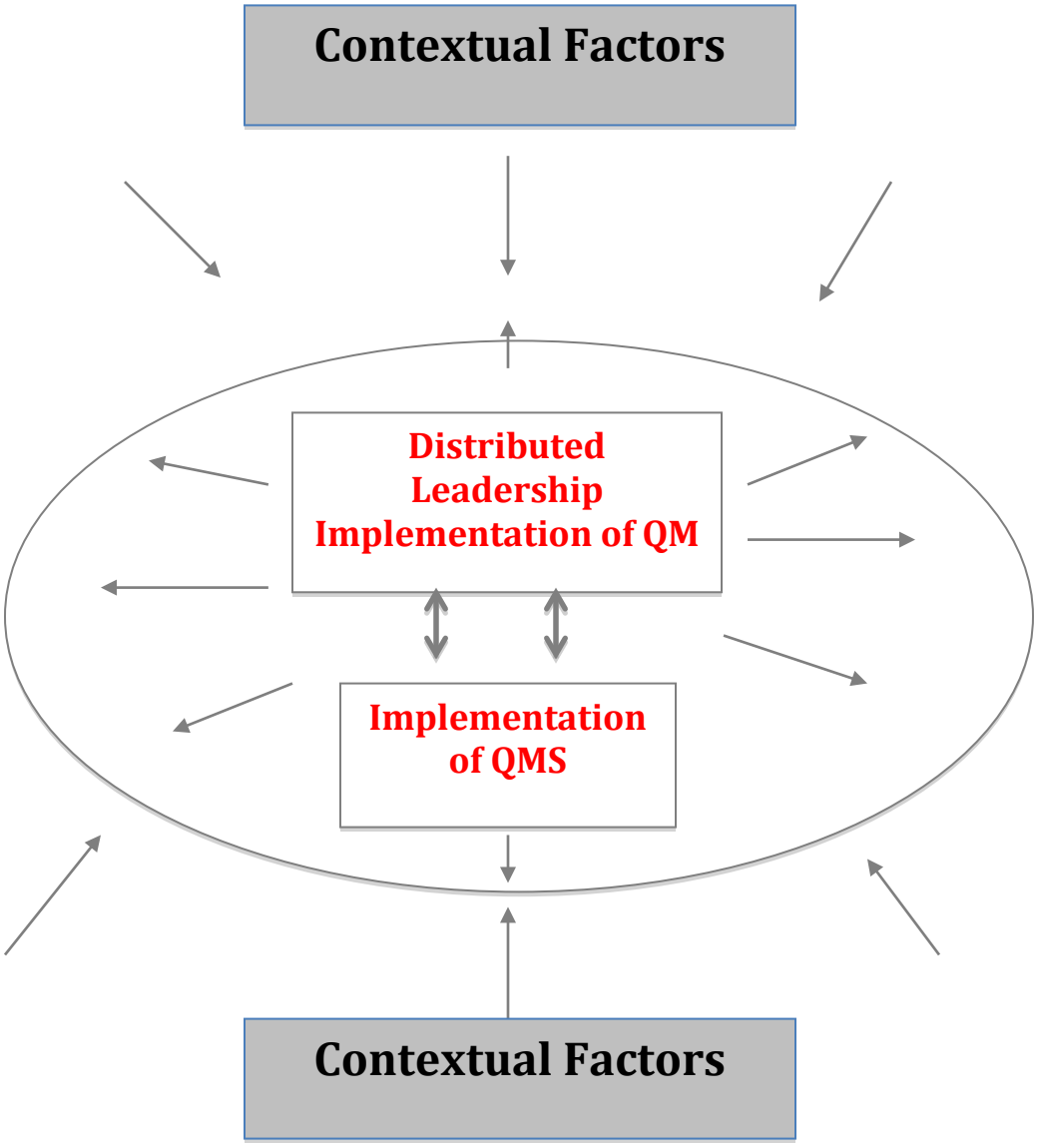

Figure 8.2: graph made by Author

8.4. Limitations

Due to diverse reasons, any research may comprise exclusive limitations particularly the restricted time frame for conducting this type of research study. This study has some limitations.

- A limitation of this study is that the design of this research study could cover other kinds of design than the ones selected to make the research broader. It could have implemented a comparative design to contrast and compare Iran with other country regarding the role of hospital leadership in implementation of quality management in private and public hospitals. However, adopting these designs for further studies would spread the research beyond the specified time frame. Furthermore, considering this research questions, the adopted designs suitably accomplish the aims and objectives of this research study. Thus, other designs recommended – though valuable for spreading the research - were not best fitted to the concentration of this research study and could have undermined the accomplishment of the current conclusions.

- The study is limited due to lack of information about previous studies regarding the implementation of quality management in Iranian hospitals. However, this has added to the value of this research study. The investigator has not had the advantage of learning from others' mistakes and building on results of other's findings.
- The generalizability of these outcomes is subject to certain limitations. For

instance, the data utilized in this research study come from service industry. Consequently, the outcomes cannot be generalized to other settings like the manufacturing industry or other countries.

- This research was conducted in Iran and interviews were translated into Persian language. The fact that these were in Persian (interviewees and researcher's native language) has given deeper expression of matters while if it were carried out in English, it would have been less informative. Utilizing two languages in a study may result in boundaries such as the additional time that the translation procedure needs. Furthermore, the content of interviews could be enhanced in appendices since the research study had to be in English and thus merely some segments were added and translated to the content of research study while there was a discussion on them. Moreover, existing software could not be used for examining content of interviews, as they did not cover Persian language.

- Gathering data for an investigation from another nation other than the researcher's university and country may limit the development of the research. Consequently, for this study merely a restricted time was organized to be spent in Iran for data gathering since the researcher would require her supervisor's direction for evaluation. The additional time needed for translation procedure had to be comprised in this period.

- Considering the outcome of the research, though findings about contingency theory could be generalized, the proposed management approaches and strategies may not be applicable in nations with very dissimilar conditions. Though the method has the potential to be repeated in any other nation (with different environment) and may/may not lead to diverse outcomes.

Having considered the restrictions associated with diverse features of this study, recommendations can be offered for further research in order to develop the knowledge in this part.

8.5. Implications and Recommendations for Policy and Practice

This current research study examined the beliefs, behaviours and actual implementations of quality management practices as perceived by top managers, physicians and nurses in private and public hospitals in Iran. It follows that quality management is a comprehensive concept. Simply stated, it cannot be implemented overnight. Ahmed (2003) accurately perceives in this respect:

> *[...] many organisations that attempt to manage change in the maturing field of Total Quality Management under-estimate the time and effort necessary in the change process* (p. 130).

The results indicate that quality management is a comprehensive process that can be practiced successfully. The study has highlighted many routes to successful quality improvement, indicating that not all organisations follow the same formula. Still, there is sufficient experience with quality efforts in Iranian private and public hospitals to

generalize about what a quality management process entails. Summarized in the following are recommendations for making effective the QM implementation in public and private hospitals in Iran.

In order to Bridge the gap between the attitudes of hospital top managers (mostly positive) towards quality management and their actual practices in the implementation of quality management in their hospitals; could be achieved by the following:

- Top management in the Iranian hospitals need to appreciate the idea that quality management system has to be implemented with clear and realistic targets and within a process of collaborating and deploying goals at all levels.

- Top management must be committed to the implementation of quality management. Top management must establish and communicate a clear vision of organisational philosophy; make it clear that everyone must be personally committed; allocate resources; define roles and responsibilities; invest the time to learn about quality issues; encourage communication between management and employees, among departments, and among various units; be a good role model in communication and action; and monitor the process. However, this research study identified that top management could not control the employees through policies and monitoring. Teamwork therefore is vital in the process of implementation of quality management. Teamwork between top managers, physician (specialist), nurses, and among departments is essential in this process.

- It is imperative that the hospital top management pay more attention to effective interaction and feedback between physicians, staff (such as nurses), and the departments and patients (as the customer) which improve the internal and external performance of the hospital.

- Since this study identified some barriers (page 457) against successful implementation of quality management, the hospital top management can deal with the barriers recognized in this research to better understand the current situation and improve the performance of hospitals.

- The current data highlight the importance of top managers and implementation teams should ensure that there is effective communication about the programme, to assist with more accurately evaluating a programme's impact. As there were many barriers identified that were likely to have reduced the effectiveness of the implementation (e.g. lack of communication), it was also suggested that managers and implementation teams should work hard to mediate these factors so that individuals have a greater likelihood of engaging with the programme. It was also found that managers were not always engaged in the programme, and as previous research emphasises the importance of tangible support from managers (White et al., 2013; Wilson, 2009) it was proposed that implementation teams should ensure that they invest in engaging managers in the process.

- The principal recommendation of this study is that different hospitals may need

different approaches to QM. The evidence from this study suggests that different hospitals may need different approaches to QM. This study draws on contingency theory and empirically shows that the implementation of QM practices depends on organizational structure, organizational culture, environmental contextual factors and also human resource management.

- The Ministry of Health and Medical University (Government) as main decision-maker should review its policy regarding the quality management system and encourage the hospitals to customize their quality management processes to suit their own context.

- The Ministry of Health in Iran is suggested to adopt a culture of quality management, and disseminate this culture in hospitals via training principals on the ground and through adopting a philosophy of QM that is compatible with the healthcare system in Iran and its administration in order to assure quality and ensure quality outputs

- Government (Ministry of Health) also should keep in mind that scientific methods (such as QMS) need to be customized according to Iran's conditions, based on contingency theory.

This research study strongly supports the view that there is no best way to implement QM; therefore, there is no single best strategy for successful quality management implementation in Iranian hospitals. The hospitals require considering their certain

(specific) influential situations. Iranian hospitals (public/private) can utilize these reflections in their efforts to implement quality management. This research study identified that successful (effective) implementation of quality management system in the Iranian hospitals (private and public) needs recognizing the existing condition in terms of implementation of quality management system, and the barriers to success. Quality management practice is a constant procedure to excellence and hence, the hospitals top management is required to take the internal and external environment into consideration while implementing quality management. The key findings of this research study can be utilized as practical and helpful proposals for the hospital leadership that intend to develop its efficiency and quality through quality management programs.

8.5.1.Recommendation for Iranian Hospitals for Further Research

- Amongst the features of the quality management content, the role of hospital leadership in implementation of quality management is vital. In initiating the implementation, the leadership of a hospital is expected to open up awareness in grasping the internal and external conditions, and filter them to frame the requirements of the hospital. The needed competency not only covers managerial knowledge and technical QM content, but also awareness of context and culture. This research study does not lead to an approach as a way for managing implementation. Finding a structure based on the discussed key matters is possible to shape an appropriate approach whether it fits the organizational situations and linked contexts or not. Thus, top management should understand how to

implement quality management through optimizing its capability to recognize the organization and its present context prior to defining the implementation strategy. However, such an ideal competent top management was not discovered in this research study. Therefore, this research study recommends that further work is needed to be done to examine how top management could respond to different contextual variables and how it should be customized.

- Drawing on contingency theory, this study suggests that Iranian hospitals need to customize (consider effecting factors such as internal and external factors) quality practices in order to be successful in the process of implementation of quality management. Drawing on the management literature, quality management practice differentiates two different groups: Quality Exploration and Quality Exploitation. Therefore, further studies need to distinguish appropriate mix of Exploration and Exploitation practices depending on the context (Sousa and Voss, 2008; Foster, 2006; Nair, 2006).

8.5.2. Recommendation for Further Research

This research study has not been completely concluding; some problems have appeared and this has led to some unanswered queries linked to the implementation of quality management in the case study hospitals. More broadly, research is therefore needed to both spread this research study and support developing quality initiatives in Iran. In additional, the significant growth of business-related activities, containing healthcare services, in Iran, the investigator proposes that further study in the public and

private hospital in Iran could be interesting, in order to recognize the changes that have happened in these more open times, as more asset has been made in the health care activity in Iran. The influence that Western management practices might have on Iranian hospital could be evaluated to realize if the Western management practices will add value to the country in the long term and if they affect human resource growth plans or not.

To conclude several recommendations are suggested for future research:

- Further studies need to be carried out in other countries in order to examine the opportunity for conducting comparative studies (between Iran and other countries) and recognize how this thesis can be contributing. Repetition of the approach of this research (using similar interview questions) in other nations to find any differences and similarities in outcomes seems invaluable.

- This research study has implications for further research on how hospitals may require customizing their quality management system over time. Since the quality management system that makes a hospital successful today does not guarantee that it will be effective in the future. The further research might feasibly offer insight into how organizations may require customizing their quality system over time to maintain high stages of quality performance.

- Further investigation and experimentation is required to replicate this research study in other industries to yield insights into the role of top management in

implementation of quality management.

- This research study could be repeated with similar organizations in different developing nations such as other Middle East countries in order to develop the comprehension of how sector-specific and cultural effects contribute to the implementation of quality management systems in healthcare organizations.

- It would be interesting to examine the role of hospital leadership in implementation of quality management in other countries such as Turkey, Malaysia and so on. This comparative research would be useful by exploring and validating the identified features from an international dimension and the impact of national culture upon the implementation process of quality management system in different countries. Such a research study would indicate whether national culture influences process of implementation or not.

- More broadly, research is also needed to determine the role of government in implementing quality management systems in healthcare organizations. Consequently, further studies could be carried out to examine the role of government in implementing the diverse quality management systems.

- The current research study has recognized the factors affecting the implementation of quality management in Iranian public and private hospitals. It is recommended that further research be done to study how these can be managed

and dealt with to overcome the barriers through developing an appropriate framework based on the results of this research study.

- The new barriers recognized to affect implementation of quality management for hospitals (private and public) context may be applicable to further similar studies in the hospital environment.
- As denoted, this research was restricted to a qualitative method. Further studies need to be carried out in order to examine and expand the findings of this research study by conducting quantitative approach. Quantitative research could analysis the incorporation of employee's main performance indicators that contribute to the accomplishment of quality goals. In terms of total quality management enablers, further research could examine models for enablers such as leadership, teams assembling, training, customer focus, communication, and staff empowerment.

As Sousa and Voss (2008) suggest more key contingency variables require to be recognized in the Operations Management. This research study examines the external and internal factors in implementation of quality management. Another possible area of future research would be considering other contingencies.

Finally, the antecedents to implementing quality practices should be examined to support comprehend why institutes implement a particular orientation to QM practices. For instance, institutional theory could assist explain why institutes implement a particular orientation to quality management practices. However, this research studies

arguments to significant contingencies that ought to be studied when implementing quality management methods. It is hoped that future research will continue to develop our comprehension of the contingent results of quality management approaches.

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Appendices:

Appendix 1: Introductory information on the profile of the Islamic Republic of Iran (I.R.I.)

Iran is the sixteenth largest country of the world and the second largest in the Middle East. It is bordered by the Caspian Sea, Armenia, Azerbaijan and Turkmenistan in the North; Persian Gulf and Gulf of Oman in the South; Iraq and Turkey in the West; and Afghanistan and Pakistan in the East (Figure 2.1). This relatively vast country is located in both the northern and eastern hemispheres of Asia in a recognized geographical region of the southwestern Asia called the Middle East.

Figure 1- Map of Iran - Source (Anonymous, 2007d)

Appendix 2: Features of Research Designs

Strategy	Form of Research Questions	Focuses on Contemporary Events	Requires control over Behaviour
Survey	Where, How, What, How many, How much	Yes	No
History	Why/ How	No	No
Case study	Why/ How	Yes	No
Experiment	Why, How	Yes	Yes
Archival Analysis	How much, How many, What, Who, where	Yes/No	No

Source: Yin (2003, p.5).

Appendix 3: Data Coding Structure

- **The Definition of Quality**

The first Question Coding:	
To Achieve the Job Correctly	To obtain the desirable results
Customers Satisfaction	Observing the standards
Paying Attention to Services' Tangible and Physical Factors	

- **Kinds of Quality Management Systems Used in Hospitals and the Ways to Evaluate Them**

The 2nd Question Coding:	
Mechanical System	Organic System

- **The Affective Roles in Implementation of Quality Management System**

The 3rd Question Coding:	
Supervisor	Coordinator
Performer	Surveyor
Decision Maker	Preparations

- **The Organization Which decides about choosing the Type of Quality Management System**

The 4th question coding:	
Health Ministry	Hospital Manager
Medical Science university	Physicians
Hospital personnel	

- **The Limitations in Effective and Optimal Implementation of Quality Management System**

The 6th question coding:	
Political Limitations	Economic limitations
Social limitations	Cultural limitations
Managerial Limitations	Individual limitations
Organizational Limitations	

- **Staffs' Ideas Regarding the Implementation Quality Management System and the Organizations Involved in the Process**

The 7th Question Coding:	
Yes- follow up and reward	Yes- lack of follow up and reward
No-follow up and reward	No- lack of follow up and reward

- **Most Effective External Factors Regarding the Implementation of Quality Management System**

The 8th Question Coding:	
International Sanctions	Financial Sources
Knowledge Sources and Lack of information	Sources (Equipment)(Physical)
Lack of Human Source	Lack of Formulated Planning

- **The Hospital directors' Leadership**

The 9th Question Coding:	
Communication Maker	Decision maker
Group's spokesman	Entrepreneur
Source Allocator	Manager of formal sessions
Leader	Manager

- **Management Patterns in Hospitals**

The 10th Question Coding:	
Scientific Management Pattern	Administrative Management Pattern
Human Management Pattern	Behavioral Management Pattern
Cooperative management pattern	Causative management pattern

- **More Important Roles in Quality Management System**

The 11th Question Coding:	
Hospital Manager	Physicians and specialist
Personnel	

- **The Barriers Facing the Chairman of Hospital in His/Her Attempt to Implement Quality Management System**

The 12th Question Coding:	
Physicians and Specialist	Deputies
Personnel	Laws and Regulations
External policies	Organizational Structure and Culture

- **The Conflicts between Specialists' Values and Managers' Goals and Strategies**

The 13th Question Coding:	
Knowledge Conflict	Interpretation Conflict
Goals Conflict	Idea Conflict

- **Interrelationships among Managers, Specialists and Governmental Departments**

The 14th Question Coding:	
One Bilateral	Bilateral
Multilateral	Lack of Relationship

- **The Effect of Culture on the Organization and Quality Management System**

The 15th Question Coding:	
Ethnic Culture	National Culture
Family Culture	Individual Culture

- **Leader's Effective Performance in the Context of Quality Management System**

The 15th Question Coding:	
Leadership	**Management**
Distribution Leadership	**Contengency Theory**
angementHuman Resourse M	

- **Similarities and Differences in Private and Public Sectors Regarding the Implementation of Quality Management System**

The 17th Question Coding:	
System-Oriented	Organizational Structure
Customer-Oriented	Organizational Culture
Personnel -Oriented	Organizational Behavior

Appendix 4: Invitation to Participant (Invitation to participate in a research Project)

Royal Docks Business School
University of East London
E16 2 RD
"Date"
Invitation to participate in a research Project

Dear Mr./ Ms. ,

The purpose of this letter is to invite you to participate in a postgraduate research study. The participation information sheet enclosed provides details of the purpose of the study, which needs to beconsidered before deciding whether you will take part or not.

You are Not obliged to take part in this study. If you do agree to participate, you are free to withdraw from the study at any time and may do so without any harm or obligation.

If you decided to participate in the study, after reviewing the information provided, please complete and return the enclosed consent from.

Participants will be provided with summary of the results if needed. Please do not hesitate to contact me if you would like to discuss the information provided or ask any questions before agreeing to take part in the study.

Many thanks for taking the time to read this information.

Yours sincerely,
Marieh Akhavan Gooran
PhD student/ Email address: Akhavan.marieh@yahoo.com

Appendix 5: Participant Information Sheet

Title of the study: *The role of Hospital Leadership in Implementation of Quality Management in the Private and Public Iranian Hospitals*

The main purpose of this research study is to contribute to the leadership and quality management literature and develop a theory of hospital leadership, focusing clearly on the role of leaders as quality managers.
This research aims to uncover the role of leadership in quality management in private and public hospitals in Iran. It can provide invaluable findings and insights to both hospital leadership and quality management in health care and determine the differences and similarities between private and public hospitals. To complete this research study, the research will use qualitative method is used.

The interviews will be conducted with doctors and team managers from four hospitals (private and public) who have different perspectives regarding the role of hospital leadership in quality management system in two different cities and sectors. Most of the interviews will be conducted in offices or coffee shops in the hospitals, either in the morning or in the afternoon. The interviewees will choose the place and time of their interviews. The average duration of each interview is an hour, some taking less than an hour and others as much as two. The average number of interviews undertaken per day was one. However, sometimes the researcher had the opportunity to conduct three interviews, at other times only one and on some days due to the busy schedule of the interviewees none.

The research work is purely for academic purposes and your information will be kept confidential. Brief quotations from the interview may be used in my thesis, but will not be attributed to you individually and thus your anonymity will be maintained. The questions are semi structured.

If the participant were happy to be involved in the project, they would sign a consent form to confirm it. However, if the participant did not want to be involved, he was thanked for their attention.

After the investigation was complete, some feedback was provided for the participant.

Researcher Contact Details:

Marieh Akhavan Gooran is PhD student in the University of East London.

Telephone: +44 7446019011

Email address: Akhavan.marieh@yahoo.com.

Chief Investigator Details:

This investigation was granted ethical approval by the University of East London Ethical Committee.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Dr. Chandler, John

Contact address:
University of East London
Docklands Campus
University Way
London E16 2RD
Telephone: +44 (0)208 223 2211 Email: j.p.chandler@uel.ac.uk

Appendix 6: Consent Form

Consent to participate in a research programme involving the use of human participates

Title of the study: *The Role of Hospital Leadership in Implementing Quality Management in the Private and Public Iranian Hospitals*.

I have read the information letter related to the above research programme in which I have been asked to participate. I have also been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study and particular data from this research will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen to the data once the research programme is completed.

I hereby fully and freely consent to participate in the study, which has been fully explained to me.
Having given consent, I understand that I have the right to withdraw from the programme at any time without hurting myself or being obliged to give any reason.

Participant's name:
Participant' signature……
Researcher's name: Marieh AkhavanGooran
Researcher's signature
Date:

Appendix 7: Interview Questions for Top Managers and Middle Managers

Top Management Interview
Name: ..... Department: .....
Your role in relation to implementation of quality management system:
.....
Date of employment: ..... .
Date: ..... Length of the interview: .....

- Define quality in hospital.
- What kind of Quality Management System do you use in your hospital and how do you evaluate it?
- What Role do you have in implementation of quality management system?
- Which organization decides about the type of quality management system?
- What Limitations are there for the effective and optimal quality management?
- Do staff offer any ideas to promote quality management system? What is that organization's reaction?
- What effects do external factors have on implementation of quality management system? Which external factors have the most effects on implementation of quality management system?
- Define hospital leadership.
- What kind of management pattern is used in the hospital?
- Who chooses the hospital leader (president)?
- Who has the much more important role in the quality management system?
- When the chairperson of hospital tries to implement the quality management system which barriers obstruct the process?
- Is there any conflict between specialists' values and the beliefs and management goals and strategy?
- What kind of communication is there between managers (managerial) and specialists and government departments?
- To what extent do you believe that culture can be influential in organization and quality management?

Thank you for your time and contribution.

Appendix 8:

Date: 15th December, 2013

Sub: Ms. Marieh Akhavan Gooran - Researcher for PhD – University of East London

Dear All,

Referring to the above-mentioned subject, you are kindly requested to cooperate with Ms. Marieh Akhavan Gooran - PhD student at University of East London - UK by providing her with necessary information in order to meet her research objectives.

Your cooperation is highly appreciated.

Leader of Hospital